SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
Filing Company:	*Pan-American Life Insurance Company*	*State Tracking Number:*	*41899*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*Middle Med Filing*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Pan-American Life Insurance Company

Product Name: Middle Med Filing	SERFF Tr Num: PNLG-125817483	State: ArkansasLH
TOI: H15G Group Health - Hospital/Surgical/Medical Expense	SERFF Status: Closed	State Tr Num: 41899
Sub-TOI: H15G.002 Large Group Only	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Keith Bridges	Disposition Date: 01/29/2009
	Date Submitted: 01/26/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 01/29/2009	
State Status Changed: 01/29/2009	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

We are submitting these forms for your review and approval. These forms describe group hospital, surgical and medical benefits and will be marketed by licensed agents to valid large employer/employee groups.

All forms are in final format. However, because Pan-American uses various fonts and layouts, we reserve the right to format the pages to conform to their printer's requirements. No change in language or reduction in font size will occur,

only a possible page break, or renumbering of pages. Pan-American also requests the right to change the paper size or to issue the forms in electronic format.

These forms are new and do not replace or supercede any forms currently on file with your Department.

If you have any questions concerning this filing, please contact me at the phone number or email address shown below.

Keith Bridges
504-566-3233
kbridges@panamericanlife.com

Company and Contact

Filing Contact Information

Bridges Keith, Senior Compliance and Contract Analyst	kbridges@panamericanlife.com	
601 poydras new orleans, LA 70130	(504) 566-3233 [Phone]	

Filing Company Information

Pan-American Life Insurance Company 601 Poydras Street new orleans, LA 70130 (504) 566-3233 ext. [Phone]	CoCode: 67539 Group Code: 525 Group Name: FEIN Number: 72-0281240 ---	State of Domicile: Louisiana Company Type: State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan-American Life Insurance Company	$100.00	01/26/2009	25260489

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/29/2009	01/29/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	01/28/2009	01/28/2009	Keith Bridges	01/29/2009	01/29/2009

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
Filing Company:	*Pan-American Life Insurance Company*	*State Tracking Number:*	*41899*
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Product Name:	*Middle Med Filing*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/29/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
Filing Company:	*Pan-American Life Insurance Company*	*State Tracking Number:*	*41899*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*Middle Med Filing*		
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form *(revised)*	Master Group Policy	Approved-Closed	Yes
Form	Master Group Policy	Replaced	Yes
Form *(revised)*	Certificate of Coverage	Approved-Closed	Yes
Form	Certificate of Coverage	Replaced	Yes
Form	Master Group Application	Approved-Closed	Yes

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
Filing Company:	*Pan-American Life Insurance Company*	*State Tracking Number:*	*41899*
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Product Name:	*Middle Med Filing*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/28/2009
Submitted Date	01/28/2009
Respond By Date	

Dear Bridges Keith,

This will acknowledge receipt of the captioned filing.

Objection 1

- Master Group Policy (Form)

Comment: Your Time Payment of Claims provision is not in compliance with Rule 43, Section 12(a).

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/29/2009
Submitted Date	01/29/2009

Dear Rosalind Minor,

Comments:

Response 1

Comments: We have revised the Time Payment of Claims in both the policy and the certificate.

Thanks,

Keith Bridges

Related Objection 1

Applies To:

- Master Group Policy (Form)

Comment:

Your Time Payment of Claims provision is not in compliance with Rule 43, Section 12(a).

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Master Group Policy	PAL-2008-P-AR		Policy/Contract/Fraternal Certificate	Initial		0	Arkansas Policy Filing Version.pdf
Previous Version							
Master Group Policy	*PAL-2008-P-AR*		*Policy/Contract/Fraternal Certificate*	*Initial*		*0*	Arkansas Policy Filing Version.pdf
Certificate of Coverage	PAL-2008-C-AR		Certificate	Initial		0	Arkansas Certificate Filing version.pdf
Previous Version							
Certificate of Coverage	*PAL-2008-C-AR*		*Certificate*	*Initial*		*0*	Arkansas Certificate Filing version.pdf

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
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No Rate/Rule Schedule items changed.

Sincerely,
Keith Bridges

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
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Product Name:	*Middle Med Filing*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: PAL-2008-P-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	PAL-2008-P-AR	Policy/Contract/Fraternal Certificate	Master Group Policy	Initial		0	Arkansas Policy Filing Version.pdf
Approved-Closed	PAL-2008-C-AR	Certificate	Certificate of Coverage	Initial		0	Arkansas Certificate Filing version.pdf
Approved-Closed	PAL-2008-APP-AR	Application/Enrollment Form	Master Group Application	Initial		0	Arkansas Middle Medical Employer Application Filing Version.pdf

PAN-AMERICAN LIFE INSURANCE COMPANY

PAN-AMERICAN LIFE CENTER
601 Poydras Street
New Orleans, Louisiana
TOLL FREE: [1-xxx-xxx-xxxx]

HOSPITAL/SURGICAL MEDICAL EXPENSE PLAN

POLICYHOLDER PLAN NUMBER:
POLICYHOLDER:
EFFECTIVE DATE:
PLAN ANNIVERSARY DATE:
PREMIUMS PAYABLE: [Monthly]
STATE: Arkansas

Pan-American Life Insurance Company agrees to pay the benefits provided in the Plan in accordance with the provisions of this Plan for each Employee of the Policyholder who is due benefits under the terms and conditions of the Plan.

This Plan is issued in consideration of the Policyholder's Application and the payment of premiums shown herein. A copy of the application is attached to and is a part of this Plan.

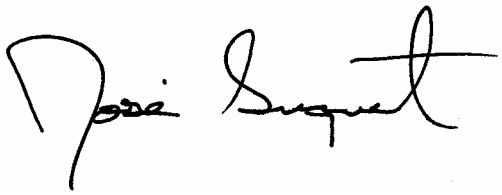
This Plan will take effect at 12:01 AM on the Date shown above. The Plan Anniversary will be the Plan Anniversary Date shown above and on the same date in each subsequent year.

The first premium is due and payable on the Effective Date. Each subsequent premium is due and payable as shown above.

This Plan, the Application, and the Employees' Enrollment Form form the entire contract between the parties.

This Plan is delivered in and is subject to the laws of the state shown above.

PAN-AMERICAN LIFE INSURANCE COMPANY



Chairman of the Board
President and Chief Executive Officer

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SECTION I: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

WHO IS AN ELIGIBLE EMPLOYEE?

Employees working at least an average of [30, 35 hours per week] will be eligible for coverage on the first day of the month following [30, 60, 90] days of employment.

WHO IS ELIGIBLE TO ENROLL AS A COVERED PERSON?

An Employee of the Policyholder.

WHO IS ELIGIBLE TO ENROLL AS A DEPENDENT?

1. Be the legal spouse of the Member; or

2. Be the natural child, step-child, or adopted child of the Member; or the child for whom the Member is the legal guardian, or the child who is the subject of a lawsuit for adoption by the Member, if the Member has the legal responsibility for the health of the child, or the child supported pursuant to a court order imposed on the Member (including a qualified medical child support order) or a grandchild of the Member who is also a Dependent of the Member for federal income tax purposes, provided that child:
    a. Is unmarried and legally dependent upon the Member for support;
    b. Has not reached age nineteen (19);
    c. Is age nineteen (19) but less than age twenty-five (25) and is a full-time student; or
    d. Is age nineteen (19) or older and is incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) years of age. You must submit proof of the child's condition and dependence to Us after the date the child ceases to qualify as a Dependent under section (b) above.

    A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

A. Enrollment during an Open Enrollment Period

If the Employee or Dependent eligibility criteria are met, the Employee may enroll during the Open Enrollment Period by submitting a completed Enrollment Form, together with any applicable premium.

If enrolled during the Open Enrollment Period, the effective date of coverage will be the Plan Anniversary Date.

B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, You become eligible for coverage as a Member or a Dependent, You may enroll as a Member within thirty-one (31) days of the day on which You met the eligibility criteria. To enroll, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, Your effective date of coverage will be the day on which You meet the eligibility criteria.

2. If You are a Member who is enrolled for Employee coverage only, You may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. Newborn children of the Member are covered for the first thirty-one (31) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.

3. If You are a Member who is enrolled for Employee and family coverage, You may enroll a newborn child prior to the birth of the child or within ninety (90) days after the child's birth. Newborn children of the Member are covered for the first ninety (90) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.

4. If You are a Member who is enrolled for Employee coverage only, You may enroll an adopted child or child for whom You have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with You for adoption or within thirty-one (31) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

5. If You are a Member who is enrolled for Employee and family coverage, You may enroll an adopted child or child for whom You have been granted legal guardianship within sixty (60) days of the date the child is legally placed with You for adoption or within sixty (60) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

C. Special Open Enrollment Period

An eligible person and/or Dependent may also be able to enroll during a special Open Enrollment Period. A special Open Enrollment Period is not available to an eligible person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An eligible person and/or Dependent do not need to elect Cobra continuation coverage to preserve special enrollment rights. Special enrollments are available to an eligible person and/or Dependent even if Cobra is elected.

A special Open Enrollment Period applies to an eligible person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Acquiring a child as a result of being a party in a suit in which the adoption of the child by the Covered Person is sought.
- Placement for adoption.
- Marriage.

A special Open Enrollment Period applies for an eligible person and/or Dependent who did not enroll during the initial Open Enrollment Period or any applicable Open Enrollment Period if the following are true:

- The eligible person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the initial Open Enrollment Period or any applicable Open Enrollment Period; and

- Coverage under the prior plan ended because of any of the following:

  - Loss of eligibility (including, without limitation, legal separation, divorce or death).

  - The Policyholder stopped paying the contributions. This is true even if the eligible person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the Policyholder.

  - In the case of Cobra continuation coverage, the coverage ended.

  - The eligible person and/or Dependent no longer lives or works in a service area if no other benefit option is available.

  - The plan no longer offers benefits to a class of individuals that include the eligible person and/or Dependent.

  - An eligible person and/or Dependent incur a claim that would exceed a lifetime limit on all benefits.

D. Completion of Enrollment Form

Each Employee will need to complete the Enrollment Form. False, incomplete or intentional misrepresentation of a material fact provided in any Enrollment Form may cause the coverage of the Employee and/or his Dependent(s) to be null and void from its inception. A statement will not be used in a contest to void, cancel or non-renew the coverage or to reduce benefits unless:

1. the statement is in a copy of the Enrollment Form; and
2. a signed copy of the Enrollment Form is or has been furnished to the Employee or his/her representative.

Coverage will only be contested because of fraud or intentional misrepresentation of a material fact on an Enrollment Form.

E. Hospitalization on the Effective Date of Coverage

If the Employee is confined in a Hospital on the effective date of coverage; We must be notified of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter.

[F. Late Enrollee

A "Late Enrollee" is a person (including Yourself) for whom You do not elect coverage within 31 days of the date the person becomes eligible for such coverage.

An eligible Employee or Dependent will be required to provide proof of good health, at his cost, if he applies for coverage more than thirty-one (31) days after he becomes eligible or if he applies for reinstatement of coverage that was cancelled at his request.

Exceptions:

- A person will not be considered to be a Late Enrollee if all of the following are met:

  You did not elect coverage for the person involved within 31 days of the date You were first eligible (or during an open enrollment) because at that time the person was covered under other creditable coverage; and

- the person loses such coverage because:
  a. of termination of employment in a class eligible for such coverage;
  b. of reduction in hours of employment;
  c. Your spouse dies;
  d. You and Your spouse divorce or are legally separated;
  e. such coverage was COBRA continuation and such continuation was exhausted; or
  f. the other plan terminates due to the employer's failure to pay the premium or for any other reason; and

- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

If You are not considered a Late Enrollee, coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if You did not elect, when the person was first eligible, coverage for:

- A child who meets the definition of a Dependent, but You elect it later in compliance with a court order requiring You to provide such coverage for Your Dependent child. Such coverage will become effective on the date specified by the Policyholder. Any limitation as to a preexisting condition may apply.

- A spouse, but You elect it later and within 31 days of a court order requiring You to provide such coverage for Your Dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.

- Yourself and You subsequently acquire a Dependent, through marriage, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

- Yourself and You subsequently acquire a Dependent, through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

- Yourself and Your spouse and You subsequently acquire a Dependent through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself, Your spouse, and any such Dependent within 90 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

G. Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of Dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date Your coverage becomes effective; and
- You make written request for coverage for the child within 31 days (60 days if You already have Dependents covered) of the date the child is placed with You for adoption.

Coverage for the child will become effective on the date the child is placed with You for adoption. If request is not made within such 31 days (60 days if You already have Dependents covered), coverage for the child will be subject to all of the terms of this Plan.

H. Special Rules Which Apply to a Child Who Must Be Covered Due to a Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom You are required to provide health coverage as the result of a qualified medical child support order issued on or after the date Your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by the Policyholder.

If You are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

SECTION 2: DEFINITIONS

Throughout this Plan, you will find many terms in capital letters. These terms have special meaning in the Plan. When you find a term which has been capitalized, its meaning may be found in this section.

ACCIDENT
An unforeseen, unexpected and involuntary event which causes the Covered Person to suffer an Injury while covered under the Plan.

ACCIDENTAL BODILY INJURY/INJURY
Physical pain or impairment of a physical condition to a Covered Person that is:

A. Unforeseen;
B. Unexpected;
C. Involuntary; and
D. Due to violent and external means.

ALTERNATE FACILITY
A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services;
- Emergency Health Services;
- Urgent Care services;
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

APPLICATION
The form completed by the Policyholder in applying for coverage under the Policy.

CALENDAR YEAR
The period from January 1 through December 31 of the same year.

COMPLICATIONS OF PREGNANCY
Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible

Complications of pregnancy does not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy

CONVALESCENT FACILITY
An institution (or distinct part thereof) which meets fully every one of the following tests:

1. it is licensed to provide, and is engaged in providing on an inpatient basis, for persons convalescing from an injury or illness:
   - professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.), under the direction of a registered graduate nurse (R.N.);
   - Physician restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. its services are provided for compensation from its patients and under the fulltime supervision of a Physician or registered graduate nurse (R.N.);
3. it provides 24 hour per day nursing services by licensed nurses under the direction of a fulltime registered graduate nurse (R.N.);
4. it maintains a complete medical record on each patient;
5. it has an effective utilization review plan; and
6. it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders.

COVERED PERSON
A person who is eligible for coverage as an Employee or as a Dependent for whom premium is paid. A person who is eligible for coverage as an Employee or a Dependent according to the class(es) shown in the Policyholder's Application. No person may be covered as both an Employee and a Dependent at the same time. If Dependent coverage is elected, only one (1) person in the family may be covered as the Employee.

COVERED SERVICE(S)
Those health services provided for the purpose of preventing, diagnosing or treating a Sickness or Injury. A Covered Service is a health care service or supply described in "Section 3: Covered Services" as a Covered Service, which is not excluded under "Section 5: Exclusions".

CREDITABLE COVERAGE
Health care coverage under any of the types of plans listed below.

- a self-funded or self-insured Employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 et seq.);
- a group health benefit plan provided by a health insurance carrier or a health maintenance organization;
- an individual health insurance policy or evidence of coverage;
- Part A or Part B of Title XVIII of the Social Security Act (42 USC Section 1395c et seq.);
- Title XIX of the Social Security Act (42 USC Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 USC Section 1396s);
- Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.);
- a medical care program of the Indian Health Service or of a tribal organization;
- a state or political subdivision health benefits risk pool;
- a health plan offered under Chapter 89 of Title 5, United States Code (5 USC Section 8901 et seq.);
- a public health plan;
- a health benefit plan under Section 5(e) of the Peace Corps Act (22 USC Section 2504(e)); and
- short-term limited duration insurance;
- CHIP Program.

Creditable Coverage does not include:

- accident-only, disability income insurance, or a combination of accident-only and disability income insurance;
- coverage issued as a supplement to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit only insurance;
- coverage for onsite medical clinics;
- other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations;
- if offered separately, coverage that provides limited scope dental or vision benefits;
- if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits;
- if offered separately, coverage for other limited benefits specified by federal regulations;
- if offered as independent, noncoordinated benefits, coverage for specified disease or illness;
- if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; or
- Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 USC Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

DEDUCTIBLE/DEDUCTIBLE AMOUNT

The amount of money the Covered Person must pay for Eligible Expenses during each Calendar Year before the Plan begins to pay benefits.

DEPENDENT

A person who is:

1. The Employee's spouse;
2. Each unmarried child from birth to age 19 who is primarily dependent upon the Employee for support and maintenance;
3. Each unmarried child at least 19 years of age to age 25 who is primarily dependent upon the Employee for support and maintenance and who is a full-time student. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months; or
4. Each unmarried child at least 19 years of age:
   a) who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental or physical handicap;
   b) who was so incapacitated and is a Covered Person under this Policy on his or her 19th birthday; and
   c) who has been continuously so incapacitated since his or her 19th birthday.

If the dependent child is a full-time student and is a member of:

- the National Guard or any reserve component of the armed forces of the United States who are called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or
- the National Guard ordered to active State duty, including duty under 35 Pa.C.S. Ch. 76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days;

and is called to military duty, coverage under this Plan will not terminate if the dependent child reaches age 23 while on military duty, or after returning home, subject to the extension qualification requirements listed below.

Coverage under this Plan shall be extended for a period equal to the duration of the dependent's service on active duty or active State duty, or until the dependent is no longer a full-time student. In order to qualify for an extension, the dependent must:

1. Submit a form approved by the Department of Military and Veterans Affairs notifying Pan-American Life Insurance Company that the dependent has been placed on active duty.
2. Submit a form approved by the Department of Military and Veterans Affairs notifying Pan-American Life Insurance Company that the dependent is no longer on active duty.
3. Submit a form approved by the Department of Military and Veterans Affairs showing that the dependent has re-enrolled as a full-time student for the first term or semester starting 60 or more days after their release from active duty.

As used above, the term "full-time student" means a student enrolled in an approved institution of higher education pursuing an approved program of education equal to or greater than 12 credit hours or its equivalent.

Children include:

- The Member's biological children.
- The Member's adopted children.
- The Member's stepchildren.
- Any other child the Member supports who has a parent-child relationship with the Member.

If the Member has had the "Declaration of Domestic Partnership" completed and signed and the Declaration is acceptable to the Policyholder, the Member may also cover a person:

1. who is Your same sex "domestic partner"; and
2. who is named as such in Your Declaration.

No person may be covered both as an Employee and Dependent and no person may be covered as a Dependent of more than one Employee.

DOCTOR/PHYSICIAN

A person who is:

A. Licensed and recognized as a Provider of medical services by the State in which he practices; and
B. Recognized as a Provider of medical services by the insurance law of the State in which the Covered Person resides; and
C. Acts within the scope of his license; and
D. Gives treatment for which benefits are payable under the Plan, and
E. Other than for dental care covered under the Policy, Not one of the following:
    1. A person who ordinarily resides in the Covered Person's household; or
    2. A member of the Covered Person's immediate family.

DOMESTIC PARTNER

A person who is mentally competent to contract and either at least 18 years old, the age of majority or legally emancipated. In order to be eligible for Dependent coverage as a Domestic Partner, the person must not be sharing a permanent resident with another person who has obtained the age of majority, and must have the competency to consent to a contract for permanent residence. Evidence that the Domestic Partner and the Employee have shared a common residence and financial assets and obligations for an extended period of time must be provided to Us.

EFFECTIVE DATE

The date coverage under the Plan goes into effect for a Policyholder and his eligible Employees. It is shown in the Summary of Benefits of the Policyholder's Plan. An Employee's Effective Date of coverage is determined by the eligibility rules of the Plan and the payment of premium.

ELIGIBLE EXPENSE
Care, treatment, services, and supplies which must be:

1. Listed as an eligible Covered Service in the Plan; or authorized by the Utilization Management Company and approved by the Plan as an alternative form of treatment or facility; and
2. Medically Necessary for the care or treatment of an Injury or Illness; and
3. Recommended and approved by a Doctor.

An expense will not be an Eligible Expense to the extent that:
1. It is in excess of the Maximum Allowable Charge; or
2. The fee or charge would not have been made in the absence of medical coverage except for Medicaid and Tax Supported Institutions.

Expenses must be incurred after the person becomes covered under the Plan. We will determine the Eligible Expenses of the Plan. Charges in excess of the Maximum Allowable Charge will not be considered as Eligible Expenses.

EMERGENCY CARE.
Health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
1. placing the person's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of a bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMPLOYEE
An Employee of the Policyholder named in the Summary of Benefits, who qualifies for coverage according to an eligible class as described in the Application.

No person may be covered as both an Employee and a Dependent at the same time. If Dependent coverage is elected, only one (1) person in the family may be covered as an Employee.

ENROLLMENT FORM
The document completed by the Employee in electing coverage under the Policyholder's Plan.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES
Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If the insured has a life-threatening Illness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Service for that Illness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those identified by the National Institutes of Health.

HOME HEALTH CARE AGENCY

This is an agency that:

1. mainly provides skilled nursing and other therapeutic services; and
2. is associated with a professional group which makes policy; this group must have at least one physician and one R.N.; and
3. has full-time supervision by a physician or a R.N.; and
4. keeps complete medical records on each person; and
5. has a full-time administrator; and
6. meets licensing standards.

HOME HEALTH CARE PLAN

This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

1. prescribed in writing and reviewed at least every two month by the attending Physician; and
2. certified by the attending Physician as necessary for medical purposes and that the care and treatment is an alternative to confinement in a Hospital or Convalescent Facility.

HOSPICE CARE

Care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

HOSPICE CARE AGENCY

This is an agency or organization which has Hospice Care available 24 hours a day. It meets any licensing or certification standards set forth by the jurisdiction where it is, and provides:

1. skilled nursing services; and
2. medical social services; and
3. psychological and dietary counseling; and
4. bereavement counseling for the immediate family.

HOSPICE CARE PROGRAM

This is a written plan of Hospice Care, which is established by and reviewed from time to time by a Physician attending the person and appropriate personnel of a Hospice Care Agency. It is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families. This includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

HOSPICE FACILITY

This is a facility, or distinct part of one, which:

1. Mainly provides inpatient Hospice Care to terminally ill persons.
2. Charges its patients.
3. Meets any licensing or certification standards set forth by the jurisdiction where it is located.
4. Keeps a medical record on each patient.
5. Provides an ongoing quality assurance program; this includes reviews by Physicians other than those who own or direct the facility.
6. Is run by a staff of Physicians; at least one such Physician must be on call at all times.
7. Provides, 24 hours a day, nursing services under the direction of a R.N.
8. Has a full-time administrator.

HOSPITAL

An institution, operated as required by law, which is all of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

ILLNESS/SICKNESS
A. A disorder or disease of the mind or body; or
B. A pregnancy.

INDIVIDUAL/INDIVIDUALIZED TREATMENT PLAN
A treatment plan with specific attainable goals and objectives that are appropriate to:
A. the patient; and
B. the program's treatment modality.

INITIAL ENROLLMENT PERIOD
The initial period of time, as we agree with the Policyholder, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

INPATIENT REHABILITATION FACILITY
A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

MAXIMUM ALLOWABLE CHARGE
The amount determined by Us to be the appropriate fee. For services rendered by a Participating Provider, an amount not to exceed the Maximum Allowable Fee.

For all other charges, an amount not exceeding a charge routinely made by Providers in the locality where the charge is incurred for similar services or supplies. Consideration will be given to:
1. The Covered Person's condition; and
2. Unusual circumstances or complications; and
3. Requirements for additional time, skill or experience.

We will determine the Maximum Allowable Charge and if it is covered by the Plan.

MAXIMUM ALLOWABLE FEE
The amount agreed upon between a Participating Provider and the Plan (after any applicable Deductible) for Eligible Expenses for care, services, supplies and treatment or other medical care. If the Utilization Management Company negotiates an amount on a pre- or post-treatment basis for non-contracted Provider services, the charges will be the negotiated amount.

MEDICALLY NECESSARY
Any services or supplies provided for the diagnosis and treatment of a specific Illness, Injury, or condition which are:
A. Ordered or recommended by a Doctor; and
B. Required for the treatment or management of a medical condition or symptom; and
C. The most appropriate supply or level of service which can safely be provided to the Covered Person; and
D. Provided in accordance with approved and generally accepted medical or surgical practice; and
E. Not for the convenience of the Covered Person, his Doctor, or another Provider; and
F. Not for services or supplies which are experimental or investigational; and
G. Furnished in the least intensive type of medical care setting required by the Covered Person's condition.

Services and supplies will not automatically be considered Medically Necessary because they were ordered by a Doctor.

MENTAL ILLNESS
Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.

NETWORK
Care, services, supplies and treatment which are obtained through a Participating Provider.

NON-NETWORK
Care, services, supplies and treatment which are obtained through a Non-Participating Provider.

OPEN ENROLLMENT PERIOD
A period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. We and the Policyholder will agree upon the period of time that is the Open Enrollment Period.

OUTPATIENT REHABILITATION FACILITY
A facility (or a special unit of a Hospital) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an outpatient basis, as authorized by law.

PARTICIPATING PROVIDER
A participating Hospital, a Primary Care Physician (PCP), a specialist Physician, and any other licensed health care services Provider who has contracted with the Us to provide health care services to Covered Persons as Network benefits.

PARTICIPATING PROVIDER ORGANIZATION/PPO
An organization which establishes an arrangement between payers (Policyholders or insurers) and health care Providers. The Providers selected for participation in the PPO agree to be reimbursed at negotiated fees for their services.

PLAN
The benefit plan elected by the Policyholder which covers its Employees.

POLICYHOLDER
The [employer or plan sponsor] named in the Summary of Benefits as the Policyholder.

PRIMARY CARE DOCTOR/PHYSICIAN
A Physician who specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

PROVIDER
Any person or health care facility duly licensed or legally authorized to render care or services covered under the Plan.

REIMBURSEMENT PERCENTAGE
The percent of Eligible Expenses payable under the Plan and shown in the Summary of Benefits.

SKILLED NURSING FACILITY
A Hospital or nursing facility that is licensed and operated as required by law.

SPECIALIST CARE DOCTOR/PHYSICIAN
A Physician who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

TOTAL DISABILITY/TOTALLY DISABLED
With respect to primary insured covered under this Plan, the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability and with respect to any other individual person insured under this Plan, confinement as a bed patient in a Hospital.

URGENT CARE CLINIC
A facility, other than a Hospital, that provides Covered Services that are required to prevent serious deterioration of Your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

UTILIZATION MANAGEMENT COMPANY/UMC
A company or organization chosen by Us which meets the standards for utilization review established by the American Managed Care and Review Association and is certified or licensed to do business in the state as a utilization review agency, if applicable.

WAITING PERIOD
The time period an Employee must be employed by the Policyholder before becoming eligible for coverage under the Policy.

WE/US/OUR/COMPANY
Refers to Pan-American Life Insurance Company.

YOU/YOUR
The Employee who is covered under the Policyholder's Plan.

SECTION 3
SUMMARY OF BENEFITS/COVERED SERVICES

Calendar Year Deductible
Network: [$250, $500, $1,000, $2,000]
Non-Network: [$500, $1,000, $2,000, $4,000]
[2 Times, 2.5 Times, 3 Times, None] Calendar Year Family Deductible Limit

Overall Maximum per Calendar Year [(does not include Inpatient Facility Expenses)]
Inpatient & Outpatient: [$10,000, $25,000, $50,000, $75,000, $100,000] (combined for Network and Non-Network Coverage)
Outpatient Limited to: [$2,500, $5,000, $7,500, $10,000] (combined for Network and Non-Network Coverage)

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Hospital Inpatient Facility Expenses. This benefit pays for charges after the deductible for a total of 30 days each Calendar Year up to the following: [$2,000 per day for the first 4 days of Hospital confinement; and $1,000 per day for days 5 through 30]; [$250, $500, $1,000, $1,000, $2,000, $2,500, $3,000 per day].	$0	Yes	[100%, 85%, 80%, 75%]	[100%, 65%, 60%, 55%]
Physician Inpatient Services.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Outpatient Surgery, Diagnostic, and Therapeutic Services.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Primary Care Doctor's Office Visits (Non-Surgical).	[$15, $20, $25, $30] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Specialist Care Doctor's Office Visits (Non-Surgical).	[$30, $35, $40] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Urgent Care Clinic Visits (Non-Surgical).	[$35, $50] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Injections Received In A Doctor's Office. Benefits are available for injections received in a Doctor's office when no other health service is received.	[$15, $20, $25, $30] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Maternity Services. Benefits for Pregnancy will be paid at the same level as Covered Services for any other condition, Illness, or Injury. This includes all maternity related services for prenatal care, postnatal care, delivery, and any related complications. We will pay Covered Services for an Inpatient say of at least: 48 hours for the mother and newborn child following a normal vaginal delivery; 96 hours for the mother and newborn child following a cesarean section delivery.				
In Vitro Fertilization. Benefits for In Vitro Fertilization will be paid at the same level as Covered Services for any other condition, Illness, or Injury. Any pre-existing condition limitation shall not exceed a period of twelve (12) months. Lifetime maximum for In Vitro Fertilization: $15,000				
Hospice Care Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Home Health Care Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Spinal Disorder Treatment Expenses. Calendar Year maximum of 2 visits.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Routine Preventive Care*. This benefit has a combined (Network or Non-Network) Calendar Year maximum of [$150, $250, $500].	[$10, $15, $20, $25, $30] [Network Only] per visit.	No (Network); [Yes] [No] (Non-Network)	100%	[85%,80%, 75%, 65%, 60%, 55%]
*Mammograms: Benefits paid for these conditions are over and above the benefits paid for any other illness or condition. We will pay not less than fifty dollars ($50.00) for each screening mammogram, which shall include payment for both the professional and technical components.				
Private Duty Nursing Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Prosthetic Devices Expenses. Calendar Year Maximum of $500.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Rehabilitation Services-Outpatient Therapy Calendar Year Maximum of $1,000.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Durable Medical Equipment Expenses. Calendar Year Maximum of $500.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Ambulance Services Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Emergency Care Services. Services that are required to stabilize or initiate treatment in an Emergency. Emergency Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. [For Emergency Room Visits as the result of a Sickness, there is a [$250, $500, $1,000, None] (combined for Network or Non-Network Coverage) Calendar Year Maximum.]	$0	Yes	[85%, 80%, 75%] after the Deductible	

ADDITIONAL BENEFITS				
COVERED SERVICE	**CO-PAY AMOUNT**	**NEED TO MEET CALENDAR YEAR DEDUCTIBLE?**	**NETWORK COVERAGE**	**NON-NETWORK COVERAGE**
Reconstructive Surgery After Mastectomy Benefits will be payable on the same basis as any other similarly covered Inpatient Hospital Expense or Medical—Surgical Expense, as shown on the Summary of Benefits.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
OTHER BENEFITS				
Other Medical Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]

Pregnancy Coverage: Benefits are payable for pregnancy-related expenses of female Employees and dependents, including Complications of Pregnancy, on the same basis as any other illness.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following an uncomplicated vaginal delivery; and a minimum of 96 hours following an uncomplicated cesarean delivery. If, after consultation with the attending Physician, a person is discharged earlier, benefits will be payable in accordance with recognized medical standards for that care by a health care provider, a registered nurse or another other appropriate licensed health care provider. The post delivery care may be provided at the women's home (at her option), a health care provider's office, a health care facility or another appropriate location. Charges for such post-delivery home visits will be paid at 100% and will not be subject to any Calendar Year Deductible.
- Authorization of the first 48 hours of such confinement following an uncomplicated vaginal delivery or the first 96 hours of such confinement following an uncomplicated cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. The Employee, his/her Physician, or other health care provider may obtain such authorization by calling the number shown on the Employee's ID Card.

Pregnancy-related expenses are not subject to any Preexisting Condition limitation.

PREEXISTING CONDITION PROVISION

A "preexisting condition" is an injury or disease for which a person:
received treatment or services; or
took prescribed drugs or medicines;

during the[90] days immediately preceding the person's effective date of coverage (or, if the Plan requires You to serve a probationary period, the [90] days immediately preceding the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Policy and Certificate, whichever applies, to determine a person's effective date of coverage.

For the first [365] days following such date, Covered Services do not include any expenses for treatment of a preexisting condition.

[With respect to a Late Enrollee, a preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment. For the first 18 months after a Late Enrollee's enrollment date, Covered Services do not include any expenses for treatment of a preexisting condition.]

Special Rules As To A Preexisting Condition:

If a person had creditable coverage, then the preexisting limitation period under this Plan will be reduced by the number of days of prior creditable coverage.

As used above: "continuous creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Members' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED

We will not treat genetic information as a preexisting condition in the absence of a diagnosis of the condition related to the information.

LIMITATIONS:

Not covered are charges for a service or supply furnished by a Participating Provider that exceeds the negotiated charge agreed to by Participating Providers.

Explanation of Some Important Plan Provisions

Network and Non-Network Coverage Year Deductible
This is the amount of Network and Non-Network care, and other health care Covered Services the Employee pays each Calendar Year before benefits are paid.
Network and Non-Network Care Family Coverage Year Deductible Limit
This limit applies to all Covered Services incurred for Network, Non-Network Care, and other health care by the Employee or his/her covered dependents. After that limit is reached, the Employee and his/her covered dependents will be deemed to have met separate Network and Non-Network coverage year Deductibles. The Network and Non-Network Family Coverage Year Deductible Limit is shown in the Summary of Benefits.

COVERED SERVICES

1. HOSPITAL INPATIENT FACILITY EXPENSES

Benefits are available for supplies, room and board, and non-Physician services received during the inpatient stay. Included are charges for services (non-Physician) made in connection with room occupancy. Benefits for Physician services are described under the section titled Physician Inpatient Services.

2. PHYSICIAN INPATIENT SERVICES (SURGICAL AND NON-SURGICAL)

Covered Services include the following charges made by a Physician:

Inpatient surgical and non-surgical services as follows:

1. Surgical services are the services of the operating Physician in performing a surgical procedure. This includes: The usual and related preoperative care; the administering of an anesthetic; the usual and related postoperative care.
2. Surgical assistance services are the services of a Physician in giving needed technical assistance to the operating Physician during a surgical service for which a benefit is paid under this Plan. No benefit is paid if such assistance is routinely done as a service by an intern; a resident Physician; or a house officer of a Hospital.
3. Anesthesia services are the services of a Physician in administering an anesthetic when a surgical services benefit is paid under this Plan. No benefit is paid if the anesthetic is administered by the operating Physician or his or her assistant.
4. Non-surgical medical treatment given to a Covered Person while confined as an inpatient in a Hospital, treatment facility, Inpatient Rehabilitation Facility, Convalescent Facility, Skilled Nursing Facility, or Hospice Facility and for consultation services given to a Covered Person while confined as an inpatient in such facility. Consultation services must be asked for by the attending Physician. A "consultation" is an exam of the Covered Person, a review of his or her x-ray and lab exams, and a review of the Covered Person's medical history. It will include a written report by the consulting Physician if the attending Physician requests one.

   No benefits are paid for consultation services:
   a. If the consulting Physician performs surgery as a result of the consultation.
   b. For staff consultations required by a facility.

3. OUTPATIENT SURGERY, DIAGNOSTIC/THERAPEUTIC AND THERAPEUTIC SERVICES

A. OUTPATIENT SURGICAL SERVICES

This benefit pays for Covered Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Surgeries performed in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

B. OUTPATIENT DIAGNOSTIC SERVICES

When ordered by a Physician, this benefit pays for Covered Services received on an outpatient basis at a Hospital or Alternate Facility for lab and radiology/x-ray, mammograms, bone mass measurement services, pap test, prostate cancer examination and testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, benefits are described under the Doctor's Office Visits Services below. It does not include CT Scans, PET Scans, MRI's, or nuclear medicine.

C. OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES-CT SCANS, PET SCANS, MRI AND NUCLEAR MEDICINE

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Diagnostic Services performed for CT Scans, PET Scans, MRI's, and Nuclear Medicine in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

D. OUTPATIENT THERAPEUTIC TREATMENTS

This benefit includes Covered Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge required for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Doctor's Office, benefits are described under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

4. PRIMARY CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)

We will pay for Covered Services received in a Primary Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Primary Care Doctor specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

5. SPECIALIST CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)

We will pay for Covered Services received in a Specialist Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Specialist Care Doctor is a Doctor who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

6. URGENT CARE CLINIC VISITS (NON-SURGICAL)

We will pay for Covered Services received in an Urgent Care Clinic for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Urgent Care Clinic Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

An Urgent Care Clinic provides services at a facility, other than a Hospital, and provides Covered Services that are required to prevent serious deterioration of the Covered Person's health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

7. INJECTIONS RECEIVED IN A DOCTOR'S OFFICE

Benefits are paid under this benefit for injections received in a Physician's office when no other health service is received.

Childhood immunizations are paid under the Routine Preventive Care Expenses benefit.

8. MATERNITY SERVICES

Benefits for Pregnancy will be paid at the same level as Covered Services for any other condition, Illness, or Injury. This includes all maternity related services for prenatal care, postnatal care, delivery, and any related complications. We will pay Covered Services for an Inpatient say of at least: 48 hours for the mother and newborn child following a normal vaginal delivery; 96 hours for the mother and newborn child following a cesarean section delivery.

9. HOSPICE CARE EXPENSES

Charges made for the following furnished to a person for Hospice Care when given as a part of a Hospice Care Program are included as Covered Services.

Facility Expenses
The charges made in its own behalf by a:

1. Hospice Facility;
2. Hospital;
3. Convalescent Facility;

which are for:
Board and room and other services and supplies furnished to a person while a full-time inpatient for:

1. pain control; and
2. other acute and chronic symptom management.

Not included is services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses

- Charges made by a Hospice Care Agency for:
  1. Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day.
  2. Medical social services under the direction of a Physician. These include assessment of the person's:
     i. social, emotional, and medical needs; and
     ii. the home and family situation;
     iii. identification of the community resources which are available to the person; and
     iv. assisting the person to obtain those resources needed to meet the person's assessed needs.
  3. Psychological and dietary counseling.
  4. Consultation or case management services by a Physician.
  5. Physical and occupational therapy.
  6. Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
  7. Medical supplies.
  8. Drugs and medicines prescribed by a Physician.
- Charges made by the providers below, but only if the provider is not an Employee of a Hospice Care Agency; and such agency retains responsibility for the care of the person.
  1. A Physician for consultant or case management services.
  2. A physical or occupational therapist.
- Not included are charges made:
  1. For bereavement counseling.
  2. For funeral arrangements.
  3. For pastoral counseling.
  4. For financial or legal counseling. This includes estate planning and the drafting of a will.
  5. For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
  6. For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

10. HOME HEALTH CARE EXPENSES

Home health care expenses are Covered Services if:
1. the charge is made by a Home Health Care Agency; and
2. the care is given under a Home Health Care Plan; and
3. the care is given to a Covered Person in his or her home; and
4. the Covered Person is homebound.

Home health care expenses include charges for:
1. Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
2. Part-time or intermittent home health aide services for patient care when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
3. Physical, occupational, and speech therapy.
4. Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.

The following to the extent they would have been covered under this Plan if the Covered Person had been Hospital confined:
1. medical supplies;
2. drugs and medicines prescribed by a physician; and
3. lab services provided by or for a home health care agency.

Home health care expenses do not include charges incurred for:

1. Services or supplies that are not a part of the Home Health Care Plan.
2. Services of a person who usually lives with a Covered Person or who is a member of the Covered Person's spouse's family.
3. Services of a social worker.
4. Transportation.
5. Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
6. Services that are custodial care. However, if the Covered Person is a minor or an adult who is dependent upon others for custodial care, coverage will be provided during times when there is a family member or caregiver present in the home to meet the Covered Person's custodial care needs. Coverage for home health care expenses is not determined by the availability of providers to provide care or services. The absence of a provider to perform a custodial care service does not cause the service to become a covered medical expense.

11. SPINAL DISORDER TREATMENT BENEFIT

Covered Services include charges incurred for:

1. manipulative (adjustive) treatment; or
2. other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Maximum Visits per Coverage Year will be payable for all expenses incurred in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full time inpatient in a Hospital
- for treatment of scoliosis
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating Physician.

12. ROUTINE PREVENTIVE CARE EXPENSES

Covered Services include charges made by a Physician for preventive care exams performed on a Covered Person for a reason other than to diagnose or treat a suspected or identified injury or disease.

Included as a part of the exam are:

1. X-rays, lab, and other tests given in connection with the exam; and
2. materials for the administration of immunizations for infectious disease and testing for tuberculosis.

Covered expenses for routine preventive care provided under this benefit include, but are not limited to, those charges made for:

1. Physical exams.
2. Cytological screening.
3. Colon cancer examinations and laboratory tests for:
   a. Covered persons who are fifty (50) years of age or older;
   b. Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
   c. Covered persons experiencing the following symptoms of colorectal cancer as determined by a licensed physician:
   (1) Bleeding from the rectum or blood in the stool; or
   (2) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days;
4. Prostate specific antigen tests and digital rectal exams.
5. Bone mass density measurements.
6. Mammograms
   a. A baseline mammogram for a woman covered by such a policy who is thirty-five (35) to forty (40) years of age;
   b. A mammogram for a woman covered by such a policy who is forty (40) to forty-nine (49) years of age, inclusive, every one (1) to two (2) years based on the recommendation of the woman's physician;
   c. A mammogram each year for a woman covered by such a policy who is at least fifty (50) years of age;
   d. Upon recommendation of a woman's physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer; and
   e. Insurance coverage for screening mammograms will not prejudice coverage for diagnostic mammograms as recommended by the woman's physician.

   We will not pay for mammography's performed in an unaccredited facility.
7. Routine Pap Smears
   Covered Services include charges incurred for:
   a. one routine gynecological exam each Calendar Year; and
   b. an annual routine Pap smear.

Mammography means radiography of the breast.

Screening mammography is a radiological procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two (2) views of each breast and includes a physician's interpretation of the results of the procedure.

Not included under this benefit are any exams; or other preventive services and supplies; which are specifically covered elsewhere in this Plan. The most that will be paid for all covered routine preventive care expenses incurred by a Covered Person in a Calendar Year under this benefit is the Routine Preventive Care Maximum.

13. PRIVATE DUTY NURSING EXPENSES

The charges of a:

1. R.N;
2. L.P.N.; or
3. nursing agency;

for private duty nursing provided on an inpatient or outpatient basis are deemed Covered Services.

No other charges made by an R.N. or L.P.N. or a nursing agency for private duty nursing are covered.

Not included as private duty nursing is:

1. that part or all of any nursing care that We determine does not require the skills of an R.N.; or
2. any nursing care given while the Covered Person is an inpatient in a health care facility, that could safely and adequately be furnished by that facility's general nursing staff if it were fully staffed.

14. PROSTHETIC DEVICES

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Doctor. Except for items required by the Women's Health and Cancer Rights Act of 1998, benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Except for items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Non-Network benefits for prosthetic devices is limited to $500 per Calendar Year. This limit applies to the total amount that We will pay for the prosthetics, and does not include any copayment or annual deductible responsibility the insured may have. Once the benefit limit is met, no additional benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.

15. REHABILITATION SERVICES – OUTPATIENT THERAPY

Benefits covered under this provision include short-term outpatient rehabilitation services for:

- Physical Therapy.
- Occupational Therapy.
- Speech Therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Doctor.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the condition of the insured within two months of the start of treatment.

Please note: We will pay benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke, or a congenital anomaly.

16. DURABLE MEDICAL EQUIPMENT

Covered Services for Durable Medical Equipment must meet the following criteria:

- Ordered or provided by a Physician for outpatient use;
- Used for medical purposes;
- Not consumable or disposable;
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost effective piece of equipment.

Durable Medical Equipment also includes hearing aids for a covered child under the age of eighteen if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a Physician and an audiological evaluation medically appropriate to the age of the child.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

We provide benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years. We will decide if the equipment should be purchased or rented. To receive Network benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify.

17. AMBULANCE SERVICE EXPENSES

This Plan pays the charges made by a professional ambulance service for:

1. the necessary air; water; or ground; transport of a Covered Person from the place where he or she has sustained an injury or is stricken by a disease to the nearest Hospital where treatment is given; and
2. the necessary non-emergency transfer of a Covered Person via ground ambulance or medical van.

Not covered are any charges made to transfer the Covered Person:

1. if ambulance service is not required by the Covered Person's physical condition;
2. if the type of ambulance service provided is not appropriate for the Covered Person's physical condition; and
3. via any form of transportation other than a professional ambulance service.

18. EMERGENCY ROOM SERVICES

We will pay for Covered Services incurred for Emergency Care due to an Illness or Injury for services Medically Necessary that do not result in Hospital Confinement. Emergency room benefits for an Illness will be paid for a Covered Person but will not exceed the overall Calendar Year maximum shown in the Summary of Benefits.

ADDITIONAL BENEFITS

1. Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:
a. All stages of the reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Benefits will be payable on the same basis as any other similarly covered Inpatient Facility Expense or medical-surgical Expense, as shown on the Summary of Benefits.

Prohibitions: We may not (a) offer the Covered Person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any Covered Person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the Physician or provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or provider to provide care to a Covered Person in a manner inconsistent with the coverage and/or benefits shown above.

Other Medical Expenses

1. Covered Services include charges incurred by a Covered Person for equipment, supplies and outpatient self-management training and education for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

   Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthodics.

   Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician includes:
   a. visits medically necessary upon the diagnosis of diabetes;
   b. visits under circumstances whereby a Physician identifies or diagnoses a significant change in the Covered Person's symptoms or conditions that necessitates changes in a Covered Person's self-management; and
   c. visits where a new medication or therapeutic process relating to the Covered Person's treatment and/or management of diabetes has been identified as medically necessary by a Physician.

2. Formulas that are equivalent to a prescription drug necessary for the therapeutic treatment of rare hereditary genetic metabolic disorders. As used in this provision: Rare hereditary genetic metabolic disorders are phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

3. The following charges when incurred by a Dependent child are included as Covered Services even though not incurred in connection with the treatment of a disease or injury.

   Children's Preventive Health Care Services

   Physician-delivered or physician-supervised services for eligible dependents from birth through age eighteen (18) years of age, with Periodic Preventive Care Visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section.

   Periodic Preventive Care Visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice, provided at the following age intervals:
   A. Birth;
   B. Two (2) weeks;
   C. Two (2) months;
   D. Four (4) months;
   E. Six (6) months;
   F. Nine (9) months;
   G. Twelve (12) months;
   H. Fifteen (15) months;
   I. Eighteen (18) months
   J. Two (2) years;
   K. Three (3) years;
   L. Four (4) years;
   M. Five (5) years;
   N. Six (6) years;
   O. Eight (8) years;
   P. Ten (10) years;
   Q. Twelve (12) years;
   R. Fourteen (14) years;
   S. Sixteen (16) years; and
   T. Eighteen (18) years.

   Benefits for recommended immunization services are payable at 100% with no deductible, copayment, coinsurance or maximum limit.

4. Covered Services include charges incurred for outpatient In Vitro Fertilization expenses, even though not incurred for treatment of a disease or injury by a female employee or by the dependent wife of a male employee. Expenses incurred for cryo preservation are also included.

   Benefits are provided on the same basis as any other illness if all of the following tests are met:
   a. The procedures are performed while she is not confined in a hospital or any other facility as an inpatient.
   b. Her oocytes are fertilized with her husband's sperm.
   c. She and her husband have a history of infertility which has lasted at least 2 years or the infertility is associated with one or more of these conditions.
      1) Endometriosis;
      2) Exposure in utero to diethylstilbestrol; known as DES;
      3) Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy; or
      4) Abnormal male factors contributing to the infertility.
   d. She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
   e. The in vitro fertilization procedures are performed:
      1) at a medical facility licensed or certified by the Arkansas Department of Health; or
      2) certified by the Arkansas Department of Health as either:
         a) meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
         b) meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

   Not more than the In Vitro Fertilization Maximum will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

5. Covered Services include charges incurred the necessary care and treatment of loss or impairment of speech or hearing payable on the same basis as any other illness.

   Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

   Coverage is not provided for hearing instruments or devices.

6. Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:
a. 48 hours following a mastectomy; and
b. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the Covered Person receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any Covered Person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any Covered Person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Covered Person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management Program uses the services of a Utilization Management Company to determine whether Covered Services are Medically Necessary. It is the Covered Person's responsibility to read and understand this benefit. The Covered Person should contact their Policyholder or customer service about how this program works.

The Utilization Management Program requires the cooperation of the Covered Person, Doctors, Providers, and Us. This program consists of medical review, medical case management, and Mental Illness and substance abuse reviews.

All Participating Providers have agreed to participate in the Utilization Management Program. This does not relieve the Covered Person of his responsibility to comply with all of the requirements of the Utilization Management Program.

For the Employee's assistance in contacting the Utilization Management Company, a toll-free number has been placed on each I.D. Card.

Following the review, the Utilization Management Company will issue written documentation to the Provider and the Covered Person which specifies the conditions of the authorization. Any payments for Covered Services are subject to all the terms and conditions of the Plan.

The ultimate decision as to whether any care should be received is between the Covered Person and the Doctor. If the Covered Person chooses to enter the Hospital or receive treatment without obtaining pre-authorization, Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of benefits will be reduced by 50%.

The Utilization Management Company may suggest the use of alternate forms of treatment or facilities which are not covered under the Plan. When this occurs, subject to Our approval, these expenses will be covered under the Plan on the same basis as the care and treatment for which they are substituted.

MEDICAL REVIEW PROGRAM

All Hospital admissions are subject to pre-authorization by a Utilization Management Company (UMC) selected by Us, and it is the Covered Person's responsibility to comply with all of the requirements of this program.

The Doctor, the Covered Person, or a member of his family must notify this organization as follows:

- Prior to a non-emergency admission;
- Within 24 hours, or on the first business day following an emergency admission.

The Utilization Management Company will review the applicable information and authorize:

- The Hospital admission, if it is Medically Necessary;
- The appropriate initial length of stay;
- Any extension beyond the original length of stay if it is Medically Necessary;
- An alternative course of treatment.

If pre-authorization is obtained, Eligible Expenses will be paid the same as any other Illness.

If pre-authorization for Hospital admissions is not obtained as stated above, benefits will be reduced after the Deductible Amount has been satisfied. Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of Benefits will be reduced by 50%.

MEDICAL CASE MANAGEMENT

Medical Case Management is intended to improve the effectiveness of health care by monitoring patient treatment plans and working directly with Doctors and patients to optimize care.

Medical Case Management is indicated only for patients who have diagnoses which typically require expensive or prolonged treatment, and which can frequently be optimized through a personal assessment. It takes physical, clinical, and psychosocial factors into consideration during the process.

Once a patient is determined to be a candidate for Medical Case Management, a case manager may perform any or all of the following:

1)Establish a working relationship with the patient's Doctors and other members of the health care team to assess the patient's needs;

2)Identify cost effective alternatives for treating the patient;

3)Develop a treatment plan that can maximize the patient's level of functioning.

SECTION 4: DESCRIPTION OF NETWORK AND NON-NETWORK BENEFITS

This section includes information about:

• Network Benefits.
• Non-Network Benefits.
• Emergency Care Services.

NETWORK BENEFITS

Network benefits are generally paid at a higher level than Non-Network benefits. Network benefits are payable for Covered Services which are either of the following:

- Provided by or under the direction of a Network Physician or other Network Provider in the Physician's office or at a Network facility.
- Emergency Care Services.

COMPARISON OF NETWORK AND NON-NETWORK BENEFITS

- Network benefits offer a higher level of benefits which means less cost to the Covered Person. See the Summary of Benefits.

- Non-Network benefits offer a lower level of benefits which means more cost to Covered Person. See the Summary of Benefits.

WHO SHOULD FILE CLAIMS

Network

Not required. We pay Network Providers directly.

Non-Network

The Employee must file claims. See Section: How to File a Claim.

PROVIDER NETWORK

Network Providers are independent practitioners. They are not Our Employees. It is each Employee's responsibility to select their Provider.

Before obtaining services, each Covered Person should always verify the Network status of a Provider. A Provider's status may change. A Provider's status can be verified by contacting customer service.

It is possible that a Covered Person might not be able to obtain services from a particular Network Provider. The network of Providers is subject to change. Or he/she might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to a Covered Person, he/she must choose another Network Provider to get Network benefits.

DESIGNATED FACILITIES AND OTHER PROVIDERS

A. If the Physician is a Network Provider, the Network Provider will notify Us of situations that might warrant a move to a designated facility or Non-Network facility or Provider if:
   1. The Covered Person has a medical condition requiring special service needs (including, but not limited to, transplants or cancer treatment); or
   2. The Covered Person requires certain complex Covered Services for which expertise is limited;

   Benefits will be paid at the Network level.

B. If the Physician is a Non-Network Provider, it is the Employee's responsibility to make sure We are notified of the above situations. If We are not notified in advance and if services are received from a Non-Network facility (regardless of whether it is a designated facility) or other Non-Network Provider, Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of Benefits for Non-Network Benefits will be reduced by 50%. Non-Network Benefits will be available if the special needs services received are Covered Services for which Benefits are provided under the Policy.

HEALTH SERVICES FROM NON-NETWORK PROVIDERS PAID AS NETWORK BENEFITS

If specific Covered Services are not available from a Network Provider, the Covered Person may be eligible for Network Benefits when Covered Services are received from Non-Network Providers. In this situation, the Network Physician will notify Us, and we will work with the Covered Person and his/her Network Physician to coordinate care through a Non-Network Provider. If We authorize care through the Non-Network Provider, benefits would be paid as if the services were received from a Network facility or provider.

CONTINUITY OF CARE

If the Covered Person is under the care of a Network Provider for one of the medical conditions below, and the Network Provider caring for him/her is terminated from the Network by Us, we can arrange, at the Covered Person's request and subject to the Provider's agreement, for continuation of Covered Services rendered by the terminated Provider as a Network Benefit.. Medical conditions and time periods for which treatment by a terminated Network Provider will be covered under the Plan as a Network Benefit are:

- A life-threatening illness. Treatment by the terminated Provider may continue as a Network Benefit until the course of treatment is complete, not to exceed three months from the effective date of termination.
- A high risk Pregnancy or a Pregnancy that is past the twenty-fourth week of Pregnancy. Treatment by the terminated Provider may continue as a Network Benefit until the postpartum services related to the delivery are complete. For the purposes of this section "life-threatening illness" means a severe, serious, or acute condition for which death is probable.

This section does not apply when:

- The reason for such termination is due to suspension, revocation, or applicable restriction of the health care Provider's license to practice in this state, or for another documented reason related to quality of care.
- His/Her choice to change health care Providers.
- The Covered Person moves out of the geographic service area of the health care Provider.
- The Covered Person requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

NON-NETWORK BENEFITS

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Services which are either of the following:

- Provided by Non-Network Providers.
- Provided under the direction of a Non-Network Physician at a Non-Network facility or program.

PRE-AUTHORIZATION REQUIREMENT

A Covered Person must obtain prior authorization from Us before getting certain Covered Services from Non-Network Providers. For more information, the Covered Person may contact customer service

Prior authorization does not mean Benefits are payable in all cases. Coverage depends on the Covered Services that are actually given, the eligibility status, and any benefit limitations.

NON-NETWORK EMERGENCY CARE SERVICES

Subject to the Deductible, we will provide Benefits for Emergency Care Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Care Services, even if the services are provided by a Non-Network Provider. Emergency Care services will be provided as a Network Benefit until the Covered Person can reasonably be expected to be transferred to Network Provider. If the Covered Person is confined in a Non-Network Hospital after receiving Emergency Care Services, We request notification within one business day or on the same day of admission if reasonably possible. No penalty will be assessed the Covered Person if notification is not given within these time frames if it is shown that it was not reasonably possible to do so. In any event, notification should be provided to Us as soon as is reasonably possible. We may elect to transfer the Covered Person to a Network Hospital as soon as it is medically appropriate to do so. If the Covered Person chooses to stay in the Non-Network Hospital after the date we decide a transfer is medically appropriate, Non-Network Benefits will be available if the continued stay is determined to be a Covered Service.

EMERGENCY CARE SERVICES includes a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is necessary to determine whether a medical emergency condition exists; necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and services originating in a Hospital emergency facility following treatment or stabilization of an emergency medical condition.

SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS

Services and supplies are not covered if they are:

1. not Medically Necessary;
2. in excess of the Maximum Allowable Charge;
3. not prescribed, recommended or approved by a Physician;
4. not furnished within the scope of the Physician's license;
5. furnished while the person is not a Covered Person by the Policy;
6. provided to the Covered Person or insurer with no legal obligation to pay;
7. furnished by a government plan or facility, unless the Covered Person is legally obligated to pay (except Medicaid and mental health benefits and mental retardation benefits provided by a tax supported institution);
8. for Custodial Care solely for personal needs, comfort or convenience of the Covered Person;
9. to control the Covered Person's environment;
10. provided by the immediate family;
11. provided mainly for education, training or vocational rehabilitation or counseling; or
12. not specifically included as a Covered Service or specifically excluded as not covered by the Plan.

Benefits are not provided for Expenses incurred from:

1. Injury or Sickness:
   a. arising out of or in connection with employment or occupation for wage or profit;
   b. covered or eligible for coverage under Workers' Compensation or any occupational disease, employer's liability or similar law,
   c. caused by an act of declared or undeclared war;
   d. occurring while on active duty with any military, naval or air force of any country or international organization, except this will not apply to orders for active service for training purposes of two month or less;
   e. resulting from the Covered Person's participation in an assault or felony, or while engaged in an illegal occupation;
   f. resulting from intentionally self-inflicted Injury, suicide or attempted suicide;
   g. resulting from voluntary taking of any gas or poison or voluntary taking of any drug, sedative, or narcotic unless prescribed by a Physician and taken according to the prescribed dosage;
   h. resulting from driving a motor vehicle while legally intoxicated according to the laws of the state where the Injury occurs;
   i. occurring while outside of the United States;

2. Procedures or devices that are:
   a. in a research or experimental stage;
   b. considered as Experimental or Investigational by the protocol of the U. S. Department of Health and Human Services or any of its agencies;
   c. not generally accepted as effective treatment by the U. S. medical community;
   d. primarily used in a laboratory or research setting that has progressed to only limited human use; or
   e. not of demonstrated value for the diagnosis and treatment of an Injury or Sickness;

3. Drugs and medicines that are:
   a. not prescribed by a Physician, or that are not approved by the U. S Food and Drug Administration;
   b. over-the-counter medications of any kind except for medications for the treatment of diabetes;
   c. nutritional supplements, minerals and vitamins, such as, but not limited to, pre-natal vitamins. This exclusion does not apply to formulas for the therapeutic treatment of rare hereditary genetic metabolic disorders;
   d. growth hormones;
   e. determined to be "less than effective" by the Drug Efficiary Study Implementation (DESI) Program;
   f. fertility agents;
   g. for cosmetic use including, but not limited to Retin-A for a Covered Person age 25 and over;
   h. anti-smoking aids, such as, but not limited to, Nicorette Gum;
   i. Dexadrine for a Covered Person over the age of 18;
   j. used to treat or cure baldness, such as, but not limited to, Rogaine or Monoxidil; or
   k. outpatient prescriptions;

4. Hospital admission from Friday 8:00 A.M. through Monday 12:01 A.M. unless surgery is performed within 24 hours of the admission, or because of an emergency;

5. Hospital Confinement that is not Medically Necessary and is solely for the convenience of the Covered Person or Physician;

6. Cosmetic surgery, which term includes but is not limited to:
   a. surgery to the upper and lower eyelid;
   b. augmentation mammoplasty;
   c. full or partial facial lifts;
   d. dermal or chemo abrasion;
   e. scar revision;
   f. otoplasty;
   g. lift, stretch or reduction of abdomen, buttocks, thighs or upper arm;
   h. silicone injections to any part of the body; and
   i. rhinoplasty;

   unless such surgery is required for a condition resulting from congenital defects or birth abnormalities of a newborn child or from Injury, and (except for a newborn child) such Injury occurred while the Covered Person was insured under the Plan;

7. Dental services or supplies, except for the following procedures:
   a. to repair damage to sound natural teeth Accidentally injured while the person is a Covered Person and the repair is done within 12 months from the date of the Injury;
   b. to remove impacted, unerupted teeth;
   c. Reconstructive Surgery for Craniofacial Abnormalities for dependent children under age 18; and
   d. Anesthesia and dental care in a hospital or ambulatory surgical center for a covered person for which the provider treating the patient certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and who:
      (1) is a child under age seven who is determined by two licensed dentists, to require without delay necessary dental treatment for a significantly complex dental condition; or
      (2) is a person with a diagnosed serious mental or physical condition; or
      (3) is a person with a significant behavioral problem as determined by the Covered Person's physician.

8. Eye exams, testing for refraction, eye or visual exercises, vision therapy, or contact lenses or eyeglasses;

9. Radial keratotomy or other surgery to correct or change refractive defects of the eye;

10. Injury resulting from travel, flight in, or descent from any aircraft owned or leased by the Covered Person, or being in any aircraft being used for one or more of the following:
    a. test or experimental purposes;
    b. speed test;
    c. exhibition or stunt flying;
    d. crop dusting or seeding;
    e. hunting, herding or herd thinning; or
    f. fire fighting;

11. Injury while riding in or on a motorized vehicle of any type designed for or primarily used for racing, speed tests, or hazardous exhibition purposes;

12. Injury while engaging in any of the following hazardous activities:
    a. hang gliding or flying an ultra light aircraft;
    b. skydiving; or
    c. scuba diving;

13. Services or supplies for:
    a. diagnosis and testing of fertility or infertility other than In Vitro Fertilization;
    b. reversal of sterilization procedure; or
    c. artificial insemination;

14. Transsexual surgery or other sex modification procedures and any related complications;

15. Marriage counseling and any therapy or counseling for sexual dysfunctions;

16. Weight loss treatment or supplies of any kind, including but not limited to:
    a. gastric bypass, gastroplasty, or gastric stapling, regardless of Physician's recommendation for medical necessity;
    b. balloon catheterization;
    c. diet or exercise programs;
    d. weight reduction programs or clinics; or
    e. liposuction or reconstructive surgery other than reconstructive surgery for Mastectomy and Craniofacial Abnormalities;

17. Exercise equipment or programs regardless of their purpose;

18. Purchase of home based artificial kidney equipment;

19. Treatment or supplies of any kind for routine foot care for (except with respect to diabetic care):
    a. paring or removal of corns, calluses or toenails;
    b. instability or imbalance of the feet; or
    c. orthopedic shoes, orthoses and other supportive devices for the feet, except if needed for conditions resulting from diabetes;

20. Acupuncture, acupressure or massage therapy;

21. Charges for failure to keep an appointment, or to complete claims forms;

22. Hospital confinement for physical therapy, rehabilitation, diagnostic x-ray and laboratory services or other diagnostic studies, except when such care or services cannot be rendered on an outpatient basis;

23. Charges for biofeedback services;

24. Charges for any maintenance type therapy not reasonably expected to improve the patient's condition;

25. Charges for:
    a. any service or supply in connection with an organ transplant, except a human to human organ transplant;
    b. any transplant which is sold rather than donated to the Covered Person; or
    c. any service or supply in connection with autologous bone marrow transplantation for treatment of any disease other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, and neuroblastomas;

26. Treatment, services or supplies for any of the following except if described as a Covered Service by the Policy:
    a. Home Health Care;
    b. abortion unless the life of the mother would be threatened if the fetus were carried to term;
    c. pre-employment or pre-marital examinations;
    d. in vitro, in ovum fertilization or Gamete Intrafallopian Transfer (GIFT);
    e. hearing aids, implants, their fitting, and related hearing tests and exams.

27. Breast reductions are excluded regardless of the Physician's recommendation of Medical Necessity except in connection with Breast Reconstructive Surgery after a covered mastectomy; or

28. In connection with a Genetic Test or chromosome analysis.

29. Charges for a Pre-Existing Condition, except as provided in the Covered Services section of the Plan.

30. Osteotomies, chelation therapy and orthomolecular medicine.

SECTION 6: TERMINATION OF COVERAGE

Termination of the Policy: The Policyholder may terminate the Policy by providing written notice to Us at least 30 days prior to termination. We may terminate the Plan on any date if:

1. The Policyholder fails to pay the premiums as required by the terms of the Plan;
2. The Policyholder has committed fraud or intentional misrepresentation of a material fact;
3. On the first renewal date following the end of a six month consecutive period during which the qualifying minimum participation requirement was not met; or;
4. The Policyholder fails to meet the required contribution requirements.

Termination of Covered Persons:

For the Employee, insurance terminates on the earliest of the following:

1. The date the Plan terminates;
2. The date any benefit of the Plan terminates, in regard to that benefit;
3. The date the Employee cancels insurance;
4. The date the Policyholder cancels insurance for the Employee. The Policyholder must give advanced written notice at least 31 days prior to the date the insurance ends;
5. The date premiums are not paid when due, subject to the Grace Period provision;
6. The date the Employee's employment is terminated;
7. The date the Employee enters full-time military service. For purposes of this insurance, active military service for training purposes of two months or less is not full-time service; or
8. The date the Employee commits fraud upon Us or intentionally misrepresents a material fact which affects his coverage under the Plan.

For the insured **Dependent**, insurance terminates of the earliest of the following:

1. The date the Employee's coverage terminates;
2. The date any benefit of the Plan terminates for the insured Dependent, in regard to that benefit;
3. The date the Employee cancels the insured Dependent's insurance;
4. The date the Policyholder cancels insurance for dependents. The Policyholder must give advanced written notice at least 31 days prior to the date the insurance ends;
5. The date premiums are not paid when due for the insured Dependent, subject to the Grace Period provision;
6. The date the insured Dependent no longer meets the definition of Dependent except that coverage for a grandchild will not terminate solely because grandchild is no longer a Dependent of the Employee for federal income tax purposes.
7. With respect to the Employee's spouse, the date the Employee is divorced from such spouse;
8. The date the insured Dependent commits fraud upon Us or misrepresents a material fact which affects his coverage under the Plan; or
9. The date the insured Dependent enters full-time military service. For purposes of this insurance, active military service for training purposes of two months or less is not full-time service.

Notwithstanding the above, in the event a Covered Person ceases to be eligible for coverage, and the Policyholder fails to report to Us the termination of coverage of the person at least 30 days prior to the pending termination date, coverage will continue for the Covered Person until the end of the month in the Policyholder notifies Us that the Coverage Person is no longer eligible for coverage. The Policyholder will be liable for all premiums for such coverage.

LIMITED EXTENSION DUE TO TOTAL DISABILITY

A Covered Person's benefits will continue to be payable under the Plan when the Policy terminates, if he;

A. Is Totally Disabled; and
B. Is confined to a Hospital for the disabling Illness or Injury at the date the Policy would otherwise terminate.

Benefits paid under this extension will be paid until the earliest of these dates:

A. The date which is ninety (90) days from the date coverage would have otherwise terminated; or
B. The date the Covered Person is no longer Hospital confined; or
C. The date on which the disabled person's Medical Benefit has reached the applicable maximum under the Plan.

This extension of coverage applies only to the disabled person and no premium is due.

SECTION 7: COORDINATION OF BENEFITS

This section applies if You are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If You are covered by more than one health benefit plan, You should file all claims with each plan.

A. Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

Plan
Any of the following that provides benefits or services for medical care or treatment with which coordination is allowed:

1. Group insurance and group subscriber contracts;
2. uninsured arrangements of group or group-type coverage;
3. group or group-type coverage through HMOs and other prepayment, group practice, and individual practice plans;
4. group-type contracts which are contracts that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.
5. the amount by which group or group-type hospital indemnity benefits exceed $100 per day;
6. the Medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and
7. Medicare or other governmental benefits, except a state plan under Medicaid. That part of the definition of "plan" may be limited to the hospital, medical, and surgical benefits of the governmental program.

Each type of coverage You have in the above categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefits rules, each of the parts shall be treated as a separate Plan.

Plan does not include any of the following:

1. individual or family insurance contracts;
2. individual or family subscriber contracts;
3. individual or family coverage through health maintenance organizations (HMOs);
4. individual or family coverage under other prepayment, group practice, and individual practice plans;
5. group or group-type hospital indemnity benefits of $100 per day or less;
6. school accident-type coverages which cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; and
7. a state plan under Medicaid;
8. plans when, by law, their benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Primary Plan.

A plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A plan is a "primary plan" if either of the following conditions is true:

1. the plan either has no order of benefit determination rules, or
2. it has rules which differ from those permitted by this subchapter.

There may be more than one "primary plan"; or all plans which cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan
A plan which is not a "primary plan." If a person is covered by more than one "secondary plan," the order of benefit determination rules of these sections decide the order in which their benefits are determined in relation to each other. The benefits of each "secondary plan" may take into consideration the benefits of the "primary plan" or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that "secondary plan.

Allowable Expense

The necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

Examples of expenses or services that are not an Allowable Expense include, but are not limited to the following:

1. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
2. The difference between the cost of a private Hospital room and the cost of a semi-private hospital room is not considered an "allowable expense" under this section unless the covered person's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.
3. If You are covered by two or more Plans that provide services or supplies on the basis of usual and customary fees, any amount in excess of the highest usual and customary fee is not an Allowable Expense.
4. When benefits are reduced under a primary plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an "allowable expense." Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.
5. When a plan provides benefits in the form of service, the Reasonable Cash Value of each service will be considered as both an "allowable expense" and a benefit paid.

Claim Determination Period
A calendar year, but it does not include any part of a year during which You are not covered under this Agreement or any date before this section or any similar provision takes effect.

Reasonable Cash Value
An amount which a duly licensed Provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care Providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

B. Order of Benefit Determination Rules

A primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. A secondary plan may take the benefits of another plan into account only when, under this subchapter, it is secondary to that other plan.

In determining the order of benefit, the first of the following rules will applies.

1. The benefits of the plan which covers the person as an Employee, member, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent. There is one exception. If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired Employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.
2. With respect to a dependent child whose parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. As used in this paragraph, the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born. If the plan does not have the rule based upon the parent's birthday, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon gender of the parent will determine the order of benefits.
3. With respect to a dependent child whose parents are separated or divorced, where two or more plans cover the child, benefits for the child are determined in this order:
    a. first, the Plan of the parent with custody of the child;
    b. Then, the Plan of the spouse of the parent with the custody of the child; and
    c. finally, the Plan of the parent not having custody of the child.
    d. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
    e. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (2) of this subsection.

4. With respect to active as related to inactive Employees, the benefits shall be determined in the following order. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's dependent) are determined before those of a plan which covers that person as a laid off or retired Employee (or as that Employee's dependent). If the other Plan does not have this rule; and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. With respect to continuation coverage, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
   a. first, the benefits of a plan covering the person as an Employee, member, or subscriber (or as that person's dependent);
   b. second, the benefits under the continuation coverage.
   c. If the other plan does not have the rule described in subparagraphs a. and b. of this paragraph, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
6. Where none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term.
   a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
   b. The start of a new plan does not include:
      (i) a change in the amount or scope of a plan's benefits;
      (ii) a change in the entity which pays, provides, or administers the plan's benefits; or
      (iii) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
   c. The person's length of time covered under a Plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a member of the group will be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

C. Effect on the Benefits of this Agreement

If we are the Secondary Plan, we may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses.

The difference between the benefits payments that we would have paid had we been the Primary Plan and the benefit payments that we actually paid as the Secondary Plan shall be recorded as a benefit reserve for You. We will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

If there is a benefit reserve, we shall use the benefit reserve recorded for You to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, Your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination.

D. Recovery of Excess Benefits

If we provide Services and Supplies that should have been paid by the primary Plan or if we provide services in excess of those for which we are obligated to provide under this Agreement, we shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We shall have the sole discretion to seek such recovery from any person to, or from whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If we request, You shall execute and deliver to such instruments and documents as we determine are necessary to secure its rights.

E. Right to Receive and Release Information

We, without consent of or notice to You, may obtain information from and release information to any Plan with respect to You in order to coordinate Your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate Your benefits pursuant to this section.

SECTION 8:
THIS PROVISION IS SUBJECT TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) AND ALL SUBSEQUENT LAWS EFFECTING THIS ACT.

This provision applies to a Policyholder with twenty (20) or more Employees on a typical business day during the preceding Calendar Year if group health coverage was provided to Employees.

Introduction

You are receiving this notice because You have recently become covered under a group health plan (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Plan and under Federal Law, You should review the Policy or Certificate of Coverage or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualifying beneficiary". You, Your spouse, and Your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
-

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "Dependent child".

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Policyholder must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or a Dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of an Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability extension of 18 month period of continuation coverage

If Your or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage.

Second qualifying event extension of 18 month period of continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare (under Part A, Part B, or both), or gets divorced or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

SECTION 9: CONTINUATION OF COVERAGE

As an alternative to continuation of coverage under COBRA, the following continuation provisions are available to the following Covered Persons:

- Employees whose coverage ends for any reason other than termination of this policy or termination of the class in which the employee was insured.
- The surviving spouse or divorced spouse of an employee whose coverage would otherwise terminate as a result of the divorce or the death of the employee.

Continuation is not available to:

- Employees whose coverage ends because of failure to pay any required contribution towards the cost of their coverage under the policy.
- Covered Persons who are eligible for Medicare.
- Covered Persons whose coverage is replaced by another group medical plan within 31 days after coverage under this policy terminates.
- Covered Persons who have not been insured for at least three months on the date their coverage under this policy ends.

Continuation of coverage is subject to payment of premium to the Policyholder by the Covered Person. The premium will be the amount of premium the Policyholder would pay for the coverage if the Covered Person was insured under this policy in the absence of this continuation provision, including amounts paid towards premium by the Policyholder and by the employee.

Coverage under this policy may be continued for up to 120 days after the month in which coverage under this policy would otherwise terminate except:

- Covered Persons whose coverage would end as a result of the divorce or death of the employee may continue coverage for up to 15 months after the end of the month in which coverage under this policy would otherwise terminate. Such continuation is subject to the Covered Person paying premium to the Policyholder in advance in three month increments.
- Covered Persons who are pregnant when coverage under this policy would otherwise terminate may continue coverage subject to the Covered Person paying premium to the Policyholder in advance in three month increments. Coverage may be continued for up to six months after the pregnancy ends, or if longer, the end of the second three month period following the three month period in which the pregnancy ends.

A Covered Person is eligible for Conversion at the end of this continuation period.

SECTION 10 – CONVERSION

Any Employee whose insurance under this Policy has been terminated for any reason, including discontinuance of this Policy in its entirety or discontinuance of an insured class will be entitled to have issued by Us an individual policy of health insurance (hereafter referred to as the "converted policy"). This provision only applies to individuals whose coverage terminates at the end of any COBRA or state continuation provision provided in the Policy. The converted policy may provide levels which are substantially similar to those provide under this Policy.

A Employee will not be entitled to have a converted policy issued if termination of the insurance under this Policy occurred for any of the following reasons:

a. the Employee failed to pay any required contribution;

b. any discontinued group coverage was immediately replaced by similar group coverage unless such person was declined coverage under the replacing group coverage; or

c. The person is, or could be, covered for Medicare benefits or similar benefits provided by any state or federal law, similar benefits provided on a group or individual basis or any benefits provided above which, together with the benefits provided under the conversion policy, would result in over-insurance.

Written application for the converted policy must be made and the first premium paid to Us not later than thirty-one (31) days after such termination. The converted policy will be issued without evidence of insurability.

The effective date of the converted policy will be the day following the termination of insurance under this Policy. The converted policy will cover the Employee and any dependents who were covered by this Policy on the date of termination of insurance.

This conversion privilege may be exercised at the Employee’s option at the end of any COBRA or state continuation of coverage provision provided under the group policy and will be available to the following:

1. the surviving spouse, if any, of the Employee with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or

2. the spouse of the Employee with respect to the spouse and children whose coverage terminates because the spouse ceases to be a qualified family member and while the Employee remains insured under the group policy, or

3. a child solely upon termination of the coverage by reason of ceasing to be a qualified family member under the group policy, or

4. the former spouse whose coverage under the group policy terminates by reason of an entry of a valid decree of divorce between the insured and spouse.

SECTION 12: GENERAL PROVISIONS

CALCULATION OF PREMIUM

On the Plan's Effective Date, the monthly premium for coverage on Employees and, if applicable, Dependents will be based on the rates shown on the Policyholder's Application for Insurance under the Plan.

We will have the right to change the premium rates or the basis on which premiums are calculated:

A. On any Plan Anniversary; or
B. On any premium due date; but not before the first Policy Anniversary and not more than once every six (6) months after the first Policy Anniversary.

We will provide written notice of any rate increase to the Policyholder at least sixty (60) days before the date the rate increase is to take effect. The rate then being charged must have been approved by Us. Any time period in which a rate must stay in effect will be shown in the Policyholder's Application.

HOW PREMIUMS ARE PAYABLE

Premiums must be paid in advance to Us at the Home Office in New Orleans, Louisiana. Premiums may also be paid to Our authorized agent in exchange for Our receipt signed by Our Officer and countersigned by the agent as evidence of such payment. Premiums may be paid as indicated on the Application. Upon written request to Us, the mode of premium payments may be changed on any Plan Anniversary with proper adjustments. The payment of any premium will not continue the Plan in force beyond the date the next premium is due, except for Grace Period provision.

GRACE PERIOD FOR PAYMENT OF PREMIUMS

If the Policyholder has not given written notice to Us to cancel the Plan, a Grace Period of at least thirty-one (31) days will be allowed after the due date for the payment of each premium after the first. The Plan will continue in force during this period. If the premium is not paid before the end of the Grace Period the Plan will cease on the last day of the Grace Period. All valid claims will be paid for a loss incurred before the expiration of the Grace Period. A pro-rata premium will be due for the Grace Period.

If, before the end of the Grace Period, the Policyholder gives written notice to Us at Our Home Office that the Plan is to be cancelled, the Plan will terminate on the effective date of such notice. A pro-rata premium will be paid for the period between the date the premium was due and the date the Plan ends.

ASSIGNMENT

The coverage provided hereunder is assignable.

CANCELLATION

All or any part of the coverage provided under the Plan may be cancelled by the Policyholder by mailing to Us written notice at least thirty-one (31) days prior to the cancellation date. If the Policyholder cancels this plan, the coverage will end at 12:00 midnight on the last day of the policy month following the required notice period.

Delivery of written notice by either the Policyholder or Us shall be equivalent of mailing.

CONFORMITY WITH STATE STATUTES

Any provision of the Plan which, on its Effective Date, is in conflict with the statutes of the state in which the Plan was issued is hereby amended to conform to the minimum requirements of such statutes, unless otherwise forbidden by the laws of the state where the Covered Person lives.

INADVERTENT ERROR

The Covered Person will not lose the amount of coverage due to him because of error or failure by the Policyholder:

A. To give the name of a Covered Person who has qualified and made the proper payment for coverage; or
B. To report a change in the amount of coverage shown in the Policy or Certificate.

In the event of the Policyholder fails to report the termination of coverage of any Covered Person, the Policyholder will be liable for a Covered Person's premium from the time the Covered Person is no longer part of the group eligible for coverage until the end of the month in which the Policyholder notifies Us that the Coverage Person is no longer eligible for coverage.

INCONTESTABILITY OF PLAN

We will not contest the Plan after it has been in force for two (2) years, except:
A. For nonpayment of premium; or
B. For fraudulent misstatements or intentional misrepresentation of a material fact by the Policyholder.

No statement made by a Covered Person relating to his insurability will be used to contest his coverage:
A. After his coverage has been in force during his lifetime for two (2) years prior to the contest; and
B. Unless such statement is in writing and signed by him.

LEGAL ACTIONS

No legal action will be brought to recover under the Plan:

A. Until sixty (60) days have elapsed after proof of claim has been filed; or
B. After three (3) years from the end of the time within which proof of claim is required by the Plan.

MODIFICATION CAN BE MADE ONLY BY AN OFFICIAL

Only Our President, Vice-President, the Secretary or an Assistant Secretary can change or waive any provision of the Plan. Any changes must be made in writing. We will not be bound by any promises or representations made by an agent or anyone other than the above.

PLAN AND APPLICATION CONSTITUTE ENTIRE CONTRACT

The Plan, Application of the Policyholder for coverage under the Plan, and the Employee's' Enrollment Forms form the entire contract between the parties. All statements made by the Policyholder or by the Employee will be deemed representations and not warranties. No statement made by the Policyholder, the Employee, or his Dependent will be used in any contest unless a copy of the instrument containing such statement is or has been furnished to the Employee.

PRONOUNS

Masculine pronouns used in the Plan will apply to both sexes.

RECORDS OF THE POLICYHOLDER

The Policyholder will give such data as may be required by Us to provide the coverage. This includes data on Covered Persons becoming covered, changes in the amount of coverage and terminations of coverage. Payroll and other personnel records pertaining to coverage under the Policyholder's Plan will be open for review by Us at any reasonable time. Any additional records of the Policyholder as may have a bearing on the coverage shall also be open for review by Us at any reasonable time. The Covered Person will not lose the amount of coverage due him because of error or failure by the Policyholder:

A. To give the name of a Covered Person who has qualified and made the proper payment for coverage; or
B. To report a change in the amount of coverage shown in the Policy or Certificate.

Failure to report the termination of coverage of any Covered Person will not continue the coverage beyond the date of termination shown in the Policyholder's Plan.

WORKER'S COMPENSATION

The Plan is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.

RIGHT OF SUBROGATION

Subrogation means We have the right to request a refund of payments made by Us under the following conditions:

We will be subrogated to any claim a Covered Person has against a third party provided:

A. The Covered Person was injured or became ill due to the act or omission of the third party, and
B. We paid benefits to the Covered Person under the Plan for such Injury or Illness.

If the Covered Person collects any sums for damages from the third party, the Covered Person will be liable to Us for the benefits We paid. If the Covered Person sues to recover his expenses from a third party, We can join in the suit. If the Covered Person does not sue, We can do so in the name of the Covered Person.

The Covered Person is obligated to:

A. Avoid doing anything that would prejudice Our right of subrogation; and
B. Execute any documents reasonably required to enforce Our right.(Failure to execute the required documents does not waive our rights to collect any sums for damages from the third party.)

SECTION 13: UNIFORM CLAIMS PROVISION

NOTICE OF CLAIM

Written notice of claim must be given to Us within twenty (20) days after the date any Injury or Illness occurs or begins. If notice is not furnished within the time limit stated above, a claim will still be considered for payment and will not be denied or reduced due to the delay if it is shown that notice was given as soon as was reasonably possible.

CLAIM FORMS

We will furnish forms for filing proof of claim after We get the notice of claim. If such forms are not furnished within fifteen (15) days of receipt of the notice, the claimant will be deemed to have met with the terms of this provision of the Plan if he submits written proof of claim within the time set forth in the Proof of Claim provision.

PROOF OF CLAIM

Written proof of claim must be given to Us within ninety (90) days after the date of treatment.

However, the claim will not be denied or reduced if:

1. It is not reasonably possible to give proof in that time; and
2. Proof is submitted within one (1) year from the date of Loss or treatment.

This one (1) year period will not apply when the Covered Person is legally incapable of submitting proof. All proofs of claim must be satisfactory to Us.

TIME PAYMENT OF CLAIMS

We will pay or deny a clean claim within 30 days after receipt if the claim was submitted electronically or within 45 days after receipt if the claim was submitted by other means.

We will notify the insured within 30 days after receipt of the claim if We determine that the claim can be processed.

If We fail to pay or deny a clean claim according to this provision, we will pay a penalty to the insured for the period beginning on the sixty-first day after receipt of the clean claim and ending on the clean claim payment date (the delinquent payment period), calculated as follows: the amount of the clean claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such penalty will be paid without any action by the insured.

PHYSICAL EXAMINATION

We, at Our own expense, will have the right to have a Covered Person examined as often as We may reasonably require, while a claim is pending.

How to File a Claim

This section provides the Employee with information about:

- How and when to file a claim.
- If the Covered Person receives Covered Services from a Network Provider, the Employee does not have to file a claim. We pay these Providers directly.
- If the Covered Person receives Covered Services from a Non-Network Provider, the Employee is responsible for filing a claim.

If the Covered Person Receives Covered Services from a Network Provider

We pay Network Providers directly for Covered Services. If a Network Provider bills the Employee for any Covered Health Service, contact Us. However, the Employee is responsible for meeting the Deductible.

If the Covered Person Receives Covered Services from a Non-Network Provider

When a Covered Person receives Covered Services from a Non-Network Provider, the Employee is responsible for requesting payment from Us. The Employee must file the claim in a format that contains all of the information we require, as described below.

The Employee must submit a request for payment of benefits within 90 days after the date of service. If the Employee does not provide this information to Us within one year of the date of service, benefits for that health service will be denied or reduced, according to the terms of the policy. This time limit does not apply if the Employee is legally incapacitated. If the claim relates to an inpatient stay, the Employee must request payment of benefits within 90 days of the date of release from the Hospital.

We will pay benefits directly to a Physician or other health care provider, and will be relieved of the obligation to pay, and of any liability for paying, those benefits to the Covered Person if:

1. the Covered Person makes a written assignment of those benefits payable to the Physician or other health care provider; and
2. the assignment is obtained by or delivered to Us with the claim for benefits.

Required Information

When requesting payment of benefits from Us, the following must be provide to Us with all of the following information:

A. The Covered Person's name and address.
B. The patient's name and age.
C. The number stated on his/her ID card.
D. The name and address of the Provider of the service(s).
E. A diagnosis from the Physician.
F. An itemized bill from the Provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
G. The date the Injury or Sickness began.
H. A statement indicating either that the Covered Person is or is not, enrolled for coverage under any other health insurance plan or program.

If the Covered Person is enrolled for other coverage, the Employee must include the name of the other carrier(s).

Payment of Benefits

You may not assign Your Benefits under the Plan to a non-Network Provider without our consent. We may, however, in our discretion, pay a non-Network Provider directly for services rendered to You.

SECTION 14: CLAIMS AND APPEAL NOTICE

Benefit Determinations

Post-service Claims
Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If Your post-service claim is denied, You will receive a written notice from us within 15 business days of receipt of the claim, as long as all needed information was provided with the claim. We will notify You within this 15 business day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend Your claim until all information is received. Once notified of the extension, You then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is determined to be eligible for payment, the claim will be paid immediately. If the claim is determined not eligible for payment and is denied, we will notify You of the denial within 15 days.

If You do not provide the needed information within the 45-day period, Your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Pre-authorization Requests for Benefits

Pre-authorization requests for Benefits are those requests that require authorization prior to receiving medical care. If You have a pre-authorization request for Benefits, and it was submitted properly with all needed information, You will receive notice of the decision from us. We will mail or otherwise transmit such notice to You and to Your Physician not later than 3 calendar days of receipt of the request. If additional information is needed to process the pre-authorization request, we will notify You of the information needed within 3 calendar days after it was received, and may request a one time extension not longer than 15 days and pend Your request until all information is received. Once notified of the extension You then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify You of a non-adverse determination within 2 working days after the information is received. We will notify You of an adverse determination within 3 working days after the information is received If You don't provide the needed information within the 45-day period, Your request for Benefits will be denied. A denial notice of an adverse determination will include:
(1) the principal reasons for the adverse determination;//
(2) the clinical basis for the adverse determination;
(3) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and
(4) a description of the procedure for the complaint and appeal process, including notice to You of Your right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations: • You will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written or electronic confirmation to follow within three days. If You filed an urgent request for Benefits improperly, we will notify You of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify You of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information. You will be notified of a benefit determination no later than 48 hours after:
• Our receipt of the requested information; or
• The end of the 48-hour period within which You were to provide the additional information, if the information is not received within that time. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and Your request to extend the treatment is an urgent request for Benefits as defined above, Your request will be decided within 24 hours, provided Your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on Your request for the extended treatment within 24 hours from receipt of Your request. If Your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and You request to extend treatment in a non-urgent circumstance, Your request will be considered a new request and decided according to post-service or pre-authorization timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If You have a question or concern about a benefit determination, You may informally contact our customer service department before requesting a formal appeal. If the customer service representative cannot resolve the issue to Your satisfaction over the phone, You may submit Your question in writing. However, if You are not satisfied with a benefit determination as described above, You may appeal it as described below, without first informally contacting a customer service representative. If You first informally contact our customer service department and later wish to request a formal appeal in writing, You should again contact customer service and request an appeal. If You request a formal appeal, a customer service representative will provide You with the appropriate address. If You are appealing an urgent claim denial, please refer to the *Urgent Appeals that Require Immediate Action* section below and contact our customer service department immediately.

How to Appeal a Claim Decision

If You disagree with a pre-authorization request for Benefits determination or post-service claim determination after following the above steps, You, your Physician, a person acting on your behalf, or other healthcare provider can contact us orally or in writing to formally request an appeal.
The request should include:
• The patient's name and the identification number from the ID card.
• The date(s) of medical service(s).
• The Provider's name.
• The reason You believe the claim should be paid.
• Any documentation or other written information to support Your request for claim payment. Within five working days from the date We receive the appeal, We will send You a letter acknowledging the date of receipt. The letter will include a list of:
(1) the procedures for appeal; and
(2) the documents that the appealing party must submit for review

When We receive an oral appeal of an adverse determination, We will send a one-page appeal form to the appealing party.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If Your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Upon request and free of charge, You have the right to reasonable access to and copies of all documents, records, and other information relevant to Your claim for Benefits.

Appeals Determinations

Pre-authorization Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on Your appeal as follows:

• For appeals of **pre-authorization requests for Benefits** as identified above, the first level appeal will be conducted and You will be notified of the decision within 3 calendar days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and You will be notified of the decision within 3 calendar days from receipt of a request for review of the first level appeal decision.

• For appeals of **post-service claims** as identified above, the first level appeal will be conducted and You will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and You will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision. For procedures associated with urgent requests for Benefits, see *Urgent Appeals That Require Immediate Action* below. If You are not satisfied with the first level appeal decision, You have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. Please note that our decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between You and Your Physician.

Urgent Appeals that Require Immediate Action 4207.357

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:
• The appeal does not need to be submitted in writing. You or your physician should call Us as soon as possible.
• We will provide You with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

SECTION 15:

NMHPA - NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

What are the special rights for childbirth under NMHPA?

Policyholder health plans and health insurers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following an uncomplicated vaginal delivery, or less than 96 hours following an uncomplicated cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). **This Act does not change the benefit limits or Deductibles of the Plan.**

WOMEN'S HEALTH AND CANCER RIGHTS ACT - IMPORTANT MASTECTOMY NOTICE

What are the rights for reconstructive surgery after a mastectomy?

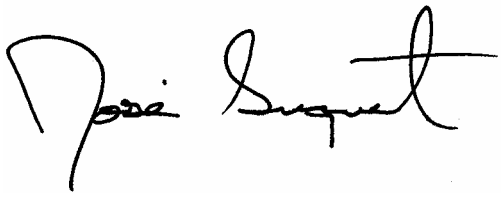
Effective October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act. The Act stipulates that any health plan that provides medical benefits for a mastectomy must also provide coverage for breast reconstruction if the Covered Person chooses to receive it. Specifically, any patient who is covered for mastectomy is also covered for reconstruction of the breast on which the mastectomy was performed, reconstruction of the other breast to achieve symmetry, and prostheses and physical complications of all stages of mastectomy including lymphedema. **This Act does not change the benefit limits or Deductibles of the Plan.**

Certificate of Insurance
under the
Group Named in the Summary of Benefits
For their Employees

Underwritten by
PAN-AMERICAN LIFE INSURANCE COMPANY
601 Poydras Street
New Orleans, Louisiana
TOLL FREE: [1-xxx-xxx-xxxx]

Pan-American Life Insurance Company has issued a Policy covering certain Employees of the Policyholder. The benefits of the Policy are described in this Certificate/booklet. Final interpretation is governed by the Policy. This Certificate/booklet replaces any and all Certificates previously issued for the Employees under the Plan. This Certificate/booklet describes the Policy in effect as of the Effective Date shown in the Summary of Benefits. This Certificate/booklet is the Employee's Certificate of Coverage only when the Employee is covered under the Policy.

PAN-AMERICAN LIFE INSURANCE COMPANY



Chairman of the Board
President and Chief Executive Officer

NOTICE CONCERNING YOUR PLAN

The benefits and provisions of the Plan are described in this Certificate. Additional benefits and provisions may apply based on the requirements of the state where the Policy is issued and the state where You live. These state benefits and provisions are described in separate amendments. See Policyholder for details.

TABLE OF CONTENTS

SECTION I: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

WHO IS AN ELIGIBLE EMPLOYEE?

Employees working at least an average of [30, 35 hours per week] will be eligible for coverage on the first day of the month following [30, 60, 90] days of employment.

TO BE ELIGIBLE TO ENROLL AS A COVERED PERSON, YOU MUST:

Be an Employee of the Policyholder.

TO BE ELIGIBLE TO ENROLL AS A DEPENDENT, YOU MUST BE:

1. Be the legal spouse of the Member; or

2. Be the natural child, step-child, or adopted child of the Member; or the child for whom the Member is the legal guardian, or the child who is the subject of a lawsuit for adoption by the Member, if the Member has the legal responsibility for the health of the child, or the child supported pursuant to a court order imposed on the Member (including a qualified medical child support order) or a grandchild of the Member who is also a Dependent of the Member for federal income tax purposes, provided that child:
    a. Is unmarried and legally dependent upon the Member for support;
    b. Has not reached age nineteen (19);
    c. Is age nineteen (19) but less than age twenty-five (25) and is a full-time student; or
    d. Is age nineteen (19) or older and is incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) years of age. You must submit proof of the child's condition and dependence to Us after the date the child ceases to qualify as a Dependent under section (b) above.

    A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

A. Enrollment during an Open Enrollment Period

If You meet the Employee or Dependent eligibility criteria, You may enroll as an Employee during the Open Enrollment Period by submitting a completed Enrollment Application, together with any applicable premium.

If enrolled during the Open Enrollment Period, the effective date of coverage will be the Plan Anniversary Date.

B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, You become eligible for coverage as a Member or a Dependent, You may enroll as a Member within thirty-one (31) days of the day on which You met the eligibility criteria. To enroll, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, Your effective date of coverage will be the day on which You meet the eligibility criteria.

2. If You are a Member who is enrolled for Employee coverage only, You may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. Newborn children of the Member are covered for the first thirty-one (31) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.

3. If You are a Member who is enrolled for Employee and family coverage, You may enroll a newborn child prior to the birth of the child or within ninety (90) days after the child's birth. Newborn children of the Member are covered for the first ninety (90) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.

4. If You are a Member who is enrolled for Employee coverage only, You may enroll an adopted child or child for whom You have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with You for adoption or within thirty-one (31) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

5. If You are a Member who is enrolled for Employee and family coverage, You may enroll an adopted child or child for whom You have been granted legal guardianship within sixty (60) days of the date the child is legally placed with You for adoption or within sixty (60) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

C. Special Open Enrollment Period

An eligible person and/or Dependent may also be able to enroll during a special Open Enrollment Period. A special Open Enrollment Period is not available to an eligible person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An eligible person and/or Dependent do not need to elect Cobra continuation coverage to preserve special enrollment rights. Special enrollments are available to an eligible person and/or Dependent even if Cobra is elected.

A special Open Enrollment Period applies to an eligible person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Acquiring a child as a result of being a party in a suit in which the adoption of the child by the Covered Person is sought.
- Placement for adoption.
- Marriage.

A special Open Enrollment Period applies for an eligible person and/or Dependent who did not enroll during the initial Open Enrollment Period or any applicable Open Enrollment Period if the following are true:

- The eligible person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the initial Open Enrollment Period or any applicable Open Enrollment Period; and

- Coverage under the prior plan ended because of any of the following:

  - Loss of eligibility (including, without limitation, legal separation, divorce or death).

  - The Policyholder stopped paying the contributions. This is true even if the eligible person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the Policyholder.

  - In the case of Cobra continuation coverage, the coverage ended.

  - The eligible person and/or Dependent no longer lives or works in a service area if no other benefit option is available.

  - The plan no longer offers benefits to a class of individuals that include the eligible person and/or Dependent.

  - An eligible person and/or Dependent incur a claim that would exceed a lifetime limit on all benefits.

D. Completion of Enrollment Application

Each Employee will need to complete the Enrollment Application. False, incomplete or intentional misrepresentation of a material fact provided in any Enrollment Application may cause the coverage of the Employee and/or his Dependent(s) to be null and void from its inception. A statement will not be used in a contest to void, cancel or non-renew Your coverage or to reduce benefits unless:

1. the statement is in a copy of the Enrollment Application; and
2. a signed copy of the Enrollment Application is or has been furnished to You or Your representative.

Coverage will only be contested because of fraud or intentional misrepresentation of a material fact on an Enrollment Application.

E. Hospitalization on the Effective Date of Coverage

If You are confined in a Hospital on the effective date of Your coverage; You must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter.

[F. Late Enrollee

A "Late Enrollee" is a person (including Yourself) for whom You do not elect coverage within 31 days of the date the person becomes eligible for such coverage.

An eligible Employee or Dependent will be required to provide proof of good health, at his cost, if he applies for coverage more than thirty-one (31) days after he becomes eligible or if he applies for reinstatement of coverage that was cancelled at his request.

Exceptions:

- A person will not be considered to be a Late Enrollee if all of the following are met:

  You did not elect coverage for the person involved within 31 days of the date You were first eligible (or during an open enrollment) because at that time the person was covered under other creditable coverage; and

- the person loses such coverage because:
  a. of termination of employment in a class eligible for such coverage;
  b. of reduction in hours of employment;
  c. Your spouse dies;
  d. You and Your spouse divorce or are legally separated;
  e. such coverage was COBRA continuation and such continuation was exhausted; or
  f. the other plan terminates due to the employer's failure to pay the premium or for any other reason; and

- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

If You are not considered a Late Enrollee, coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if You did not elect, when the person was first eligible, coverage for:

- A child who meets the definition of a Dependent, but You elect it later in compliance with a court order requiring You to provide such coverage for Your Dependent child. Such coverage will become effective on the date specified by the Policyholder. Any limitation as to a preexisting condition may apply.

- A spouse, but You elect it later and within 31 days of a court order requiring You to provide such coverage for Your Dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.

- Yourself and You subsequently acquire a Dependent, through marriage, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

- Yourself and You subsequently acquire a Dependent, through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

- Yourself and Your spouse and You subsequently acquire a Dependent through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself, Your spouse, and any such Dependent within 90 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

G. Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of Dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date Your coverage becomes effective; and
- You make written request for coverage for the child within 31 days (60 days if You already have Dependents covered) of the date the child is placed with You for adoption.

Coverage for the child will become effective on the date the child is placed with You for adoption. If request is not made within such 31 days (60 days if You already have Dependents covered), coverage for the child will be subject to all of the terms of this Plan.

H. Special Rules Which Apply to a Child Who Must Be Covered Due to a Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom You are required to provide health coverage as the result of a qualified medical child support order issued on or after the date Your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by the Policyholder.

If You are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

SECTION 2: DEFINITIONS

Throughout this Plan, you will find many terms in capital letters. These terms have special meaning in the Plan. When you find a term which has been capitalized, its meaning may be found in this section.

ACCIDENT
An unforeseen, unexpected and involuntary event which causes the Covered Person to suffer an Injury while covered under the Plan.

ACCIDENTAL BODILY INJURY/INJURY
Physical pain or impairment of a physical condition to a Covered Person that is:

A. Unforeseen;
B. Unexpected;
C. Involuntary; and
D. Due to violent and external means.

ALTERNATE FACILITY
A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services;
- Emergency Health Services;
- Urgent Care services;
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

APPLICATION
The form completed by the Policyholder in applying for coverage under the Policy.

CALENDAR YEAR
The period from January 1 through December 31 of the same year.

COMPLICATIONS OF PREGNANCY
Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible

Complications of pregnancy does not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy

CONVALESCENT FACILITY
An institution (or distinct part thereof) which meets fully every one of the following tests:

1. it is licensed to provide, and is engaged in providing on an inpatient basis, for persons convalescing from an injury or illness:
   - professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.), under the direction of a registered graduate nurse (R.N.);
   - Physician restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. its services are provided for compensation from its patients and under the fulltime supervision of a Physician or registered graduate nurse (R.N.);
3. it provides 24 hour per day nursing services by licensed nurses under the direction of a fulltime registered graduate nurse (R.N.);
4. it maintains a complete medical record on each patient;
5. it has an effective utilization review plan; and
6. it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders.

COVERED PERSON
A person who is eligible for coverage as an Employee or as a Dependent for whom premium is paid. A person who is eligible for coverage as an Employee or a Dependent according to the class(es) shown in the Policyholder's Application. No person may be covered as both an Employee and a Dependent at the same time. If Dependent coverage is elected, only one (1) person in the family may be covered as the Employee.

COVERED SERVICE(S)
Those health services provided for the purpose of preventing, diagnosing or treating a Sickness or Injury. A Covered Service is a health care service or supply described in "Section 3: Covered Services" as a Covered Service, which is not excluded under "Section 5: Exclusions".

CREDITABLE COVERAGE
Health care coverage under any of the types of plans listed below.

- a self-funded or self-insured Employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 et seq.);
- a group health benefit plan provided by a health insurance carrier or a health maintenance organization;
- an individual health insurance policy or evidence of coverage;
- Part A or Part B of Title XVIII of the Social Security Act (42 USC Section 1395c et seq.);
- Title XIX of the Social Security Act (42 USC Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 USC Section 1396s);
- Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.);
- a medical care program of the Indian Health Service or of a tribal organization;
- a state or political subdivision health benefits risk pool;
- a health plan offered under Chapter 89 of Title 5, United States Code (5 USC Section 8901 et seq.);
- a public health plan;
- a health benefit plan under Section 5(e) of the Peace Corps Act (22 USC Section 2504(e)); and
- short-term limited duration insurance;
- CHIP Program.

Creditable Coverage does not include:

- accident-only, disability income insurance, or a combination of accident-only and disability income insurance;
- coverage issued as a supplement to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit only insurance;
- coverage for onsite medical clinics;
- other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations;
- if offered separately, coverage that provides limited scope dental or vision benefits;
- if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits;
- if offered separately, coverage for other limited benefits specified by federal regulations;
- if offered as independent, noncoordinated benefits, coverage for specified disease or illness;
- if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; or
- Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 USC Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

DEDUCTIBLE/DEDUCTIBLE AMOUNT

The amount of money the Covered Person must pay for Eligible Expenses during each Calendar Year before the Plan begins to pay benefits.

DEPENDENT

A person who is:

1. The Employee's spouse;
2. Each unmarried child from birth to age 19 who is primarily dependent upon the Employee for support and maintenance;
3. Each unmarried child at least 19 years of age to age 25 who is primarily dependent upon the Employee for support and maintenance and who is a full-time student. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months; or
4. Each unmarried child at least 19 years of age:
   a) who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental or physical handicap;
   b) who was so incapacitated and is a Covered Person under this Policy on his or her 19th birthday; and
   c) who has been continuously so incapacitated since his or her 19th birthday.

If the dependent child is a full-time student and is a member of:

- the National Guard or any reserve component of the armed forces of the United States who are called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or
- the National Guard ordered to active State duty, including duty under 35 Pa.C.S. Ch. 76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days;

and is called to military duty, coverage under this Plan will not terminate if the dependent child reaches age 23 while on military duty, or after returning home, subject to the extension qualification requirements listed below.

Coverage under this Plan shall be extended for a period equal to the duration of the dependent's service on active duty or active State duty, or until the dependent is no longer a full-time student. In order to qualify for an extension, the dependent must:

1. Submit a form approved by the Department of Military and Veterans Affairs notifying Pan-American Life Insurance Company that the dependent has been placed on active duty.
2. Submit a form approved by the Department of Military and Veterans Affairs notifying Pan-American Life Insurance Company that the dependent is no longer on active duty.
3. Submit a form approved by the Department of Military and Veterans Affairs showing that the dependent has re-enrolled as a full-time student for the first term or semester starting 60 or more days after their release from active duty.

As used above, the term "full-time student" means a student enrolled in an approved institution of higher education pursuing an approved program of education equal to or greater than 12 credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study.

Children include:

- The Member’s biological children.
- The Member’s adopted children.
- The Member’s stepchildren.
- Any other child the Member supports who has a parent-child relationship with the Member.

If the Member has had the "Declaration of Domestic Partnership" completed and signed and the Declaration is acceptable to the Policyholder, the Member may also cover a person:

1. who is Your same sex "domestic partner"; and
2. who is named as such in Your Declaration.

No person may be covered both as an Employee and Dependent and no person may be covered as a Dependent of more than one Employee.

DOCTOR/PHYSICIAN

A person who is:

A. Licensed and recognized as a Provider of medical services by the State in which he practices; and
B. Recognized as a Provider of medical services by the insurance law of the State in which the Covered Person resides; and
C. Acts within the scope of his license; and
D. Gives treatment for which benefits are payable under the Plan, and
E. Other than for dental care covered under the Policy, Not one of the following:
    1. A person who ordinarily resides in the Covered Person's household; or
    2. A member of the Covered Person's immediate family.

DOMESTIC PARTNER

A person who is mentally competent to contract and either at least 18 years old, the age of majority or legally emancipated. In order to be eligible for Dependent coverage as a Domestic Partner, the person must not be sharing a permanent resident with another person who has obtained the age of majority, and must have the competency to consent to a contract for permanent residence. Evidence that the Domestic Partner and the Employee have shared a common residence and financial assets and obligations for an extended period of time must be provided to Us.

EFFECTIVE DATE

The date coverage under the Plan goes into effect for a Policyholder and his eligible Employees. It is shown in the Summary of Benefits of the Policyholder's Plan. An Employee's Effective Date of coverage is determined by the eligibility rules of the Plan and the payment of premium.

ELIGIBLE EXPENSE
Care, treatment, services, and supplies which must be:

1. Listed as an eligible Covered Service in the Plan; or authorized by the Utilization Management Company and approved by the Plan as an alternative form of treatment or facility; and
2. Medically Necessary for the care or treatment of an Injury or Illness; and
3. Recommended and approved by a Doctor.

An expense will not be an Eligible Expense to the extent that:

1. It is in excess of the Maximum Allowable Charge; or
2. The fee or charge would not have been made in the absence of medical coverage except for Medicaid and Tax Supported Institutions.

Expenses must be incurred after the person becomes covered under the Plan. We will determine the Eligible Expenses of the Plan. Charges in excess of the Maximum Allowable Charge will not be considered as Eligible Expenses.

EMERGENCY CARE.
Health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

1. placing the person's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of a bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMPLOYEE
An Employee of the Policyholder named in the Summary of Benefits, who qualifies for coverage according to an eligible class as described in the Application.

No person may be covered as both an Employee and a Dependent at the same time. If Dependent coverage is elected, only one (1) person in the family may be covered as an Employee.

ENROLLMENT FORM
The document completed by the Employee in electing coverage under the Policyholder's Plan.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES
Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If the insured has a life-threatening Illness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Service for that Illness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those identified by the National Institutes of Health.

HOME HEALTH CARE AGENCY

This is an agency that:

1. mainly provides skilled nursing and other therapeutic services; and
2. is associated with a professional group which makes policy; this group must have at least one physician and one R.N.; and
3. has full-time supervision by a physician or a R.N.; and
4. keeps complete medical records on each person; and
5. has a full-time administrator; and
6. meets licensing standards.

HOME HEALTH CARE PLAN

This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

1. prescribed in writing and reviewed at least every two month by the attending Physician; and
2. certified by the attending Physician as necessary for medical purposes and that the care and treatment is an alternative to confinement in a Hospital or convalescent facility.

HOSPICE CARE

Care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

HOSPICE CARE AGENCY

This is an agency or organization which has Hospice Care available 24 hours a day. It meets any licensing or certification standards set forth by the jurisdiction where it is, and provides:

1. skilled nursing services; and
2. medical social services; and
3. psychological and dietary counseling; and
4. bereavement counseling for the immediate family.

HOSPICE CARE PROGRAM

This is a written plan of Hospice Care, which is established by and reviewed from time to time by a Physician attending the person and appropriate personnel of a Hospice Care Agency. It is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families. This includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

HOSPICE FACILITY

This is a facility, or distinct part of one, which:

1. Mainly provides inpatient Hospice Care to terminally ill persons.
2. Charges its patients.
3. Meets any licensing or certification standards set forth by the jurisdiction where it is located.
4. Keeps a medical record on each patient.
5. Provides an ongoing quality assurance program; this includes reviews by Physicians other than those who own or direct the facility.
6. Is run by a staff of Physicians; at least one such Physician must be on call at all times.
7. Provides, 24 hours a day, nursing services under the direction of a R.N.
8. Has a full-time administrator.

HOSPITAL

An institution, operated as required by law, which is all of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

ILLNESS/SICKNESS
A. A disorder or disease of the mind or body; or
B. A pregnancy.

INDIVIDUAL/INDIVIDUALIZED TREATMENT PLAN
A treatment plan with specific attainable goals and objectives that are appropriate to:
A. the patient; and
B. the program's treatment modality.

INITIAL ENROLLMENT PERIOD
The initial period of time, as we agree with the Policyholder, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

INPATIENT REHABILITATION FACILITY
A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

MAXIMUM ALLOWABLE CHARGE
The amount determined by Us to be the appropriate fee. For services rendered by a Participating Provider, an amount not to exceed the Maximum Allowable Fee.

For all other charges, an amount not exceeding a charge routinely made by Providers in the locality where the charge is incurred for similar services or supplies. Consideration will be given to:
1. The Covered Person's condition; and
2. Unusual circumstances or complications; and
3. Requirements for additional time, skill or experience.

We will determine the Maximum Allowable Charge and if it is covered by the Plan.

MAXIMUM ALLOWABLE FEE
The amount agreed upon between a Participating Provider and the Plan (after any applicable Deductible) for Eligible Expenses for care, services, supplies and treatment or other medical care. If the Utilization Management Company negotiates an amount on a pre- or post-treatment basis for non-contracted Provider services, the charges will be the negotiated amount.

MEDICALLY NECESSARY
Any services or supplies provided for the diagnosis and treatment of a specific Illness, Injury, or condition which are:
A. Ordered or recommended by a Doctor; and
B. Required for the treatment or management of a medical condition or symptom; and
C. The most appropriate supply or level of service which can safely be provided to the Covered Person; and
D. Provided in accordance with approved and generally accepted medical or surgical practice; and
E. Not for the convenience of the Covered Person, his Doctor, or another Provider; and
F. Not for services or supplies which are experimental or investigational; and
G. Furnished in the least intensive type of medical care setting required by the Covered Person's condition.

Services and supplies will not automatically be considered Medically Necessary because they were ordered by a Doctor.

MENTAL ILLNESS
Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.

NETWORK
Care, services, supplies and treatment which are obtained through a Participating Provider.

NON-NETWORK
Care, services, supplies and treatment which are obtained through a Non-Participating Provider.

OPEN ENROLLMENT PERIOD
A period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. We and the Policyholder will agree upon the period of time that is the Open Enrollment Period.

OUTPATIENT REHABILITATION FACILITY
A facility (or a special unit of a Hospital) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an outpatient basis, as authorized by law.

PARTICIPATING PROVIDER
A participating Hospital, a Primary Care Physician (PCP), a specialist Physician, and any other licensed health care services Provider who has contracted with the Us to provide health care services to Covered Persons as Network benefits.

PARTICIPATING PROVIDER ORGANIZATION/PPO
An organization which establishes an arrangement between payers (Policyholders or insurers) and health care Providers. The Providers selected for participation in the PPO agree to be reimbursed at negotiated fees for their services.

PLAN
The benefit plan elected by the Policyholder which covers its Employees.

POLICYHOLDER
The [employer or plan sponsor] named in the Summary of Benefits as the Policyholder.

PRIMARY CARE DOCTOR/PHYSICIAN
A Physician who specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

PROVIDER
Any person or health care facility duly licensed or legally authorized to render care or services covered under the Plan.

REIMBURSEMENT PERCENTAGE
The percent of Eligible Expenses payable under the Plan and shown in the Summary of Benefits.

SKILLED NURSING FACILITY
A Hospital or nursing facility that is licensed and operated as required by law.

SPECIALIST CARE DOCTOR/PHYSICIAN
A Physician who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

TOTAL DISABILITY/TOTALLY DISABLED
With respect to primary insured covered under this Plan, the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability and with respect to any other individual person insured under this Plan, confinement as a bed patient in a Hospital.

URGENT CARE CLINIC
A facility, other than a Hospital, that provides Covered Services that are required to prevent serious deterioration of Your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

UTILIZATION MANAGEMENT COMPANY/UMC
A company or organization chosen by Us which meets the standards for utilization review established by the American Managed Care and Review Association and is certified or licensed to do business in the state as a utilization review agency, if applicable.

WAITING PERIOD
The time period an Employee must be employed by the Policyholder before becoming eligible for coverage under the Policy.

WE/US/OUR/COMPANY
Refers to Pan-American Life Insurance Company.

YOU/YOUR
The Employee who is covered under the Policyholder's Plan.

SECTION 3
SUMMARY OF BENEFITS/COVERED SERVICES

Calendar Year Deductible
Network: [$250, $500, $1,000, $2,000]
Non-Network: [$500, $1,000, $2,000, $4,000]
[2 Times, 2.5 Times, 3 Times, None] Calendar Year Family Deductible Limit

Overall Maximum per Calendar Year [(does not include Inpatient Facility Expenses)]
Inpatient & Outpatient: [$10,000, $25,000, $50,000, $75,000, $100,000] (combined for Network and Non-Network Coverage)
Outpatient Limited to: [$2,500, $5,000, $7,500, $10,000] (combined for Network and Non-Network Coverage)

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Hospital Inpatient Facility Expenses. This benefit pays for charges after the deductible for a total of 30 days each Calendar Year up to the following: [$2,000 per day for the first 4 days of Hospital confinement; and $1,000 per day for days 5 through 30]; [$250, $500, $1,000, $1,000, $2,000, $2,500, $3,000 per day].	$0	Yes	[100%, 85%, 80%, 75%]	[100%, 65%, 60%, 55%]
Physician Inpatient Services.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Outpatient Surgery, Diagnostic, and Therapeutic Services.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Primary Care Doctor's Office Visits (Non-Surgical).	[$15, $20, $25, $30] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Specialist Care Doctor's Office Visits (Non-Surgical).	[$30, $35, $40] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Urgent Care Clinic Visits (Non-Surgical).	[$35, $50] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Injections Received In A Doctor's Office. Benefits are available for injections received in a Doctor's office when no other health service is received.	[$15, $20, $25, $30] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Maternity Services. Benefits for Pregnancy will be paid at the same level as Covered Services for any other condition, Illness, or Injury. This includes all maternity related services for prenatal care, postnatal care, delivery, and any related complications. We will pay Covered Services for an Inpatient say of at least: 48 hours for the mother and newborn child following a normal vaginal delivery; 96 hours for the mother and newborn child following a cesarean section delivery.				
In Vitro Fertilization. Benefits for In Vitro Fertilization will be paid at the same level as Covered Services for any other condition, Illness, or Injury. Any pre-existing condition limitation shall not exceed a period of twelve (12) months. Lifetime maximum for In Vitro Fertilization: $15,000				
Hospice Care Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Home Health Care Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Spinal Disorder Treatment Expenses. Calendar Year maximum of 2 visits.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Routine Preventive Care*. This benefit has a combined (Network or Non-Network) Calendar Year maximum of [$150, $250, $500].	[$10, $15, $20, $25, $30] [Network Only] per visit.	No (Network); [Yes] [No] (Non-Network)	100%	[85%,80%, 75%, 65%, 60%, 55%]
Private Duty Nursing Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Prosthetic Devices Expenses. Calendar Year Maximum of $500.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Rehabilitation Services-Outpatient Therapy Calendar Year Maximum of $1,000.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Durable Medical Equipment Expenses. Calendar Year Maximum of $500.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Ambulance Services Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Emergency Care Services. Services that are required to stabilize or initiate treatment in an Emergency. Emergency Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. [For Emergency Room Visits as the result of a Sickness, there is a [$250, $500, $1,000, None] (combined for Network or Non-Network Coverage) Calendar Year Maximum.]	$0	Yes	[85%, 80%, 75%] after the Deductible	

ADDITIONAL BENEFITS				
COVERED SERVICE	**CO-PAY AMOUNT**	**NEED TO MEET CALENDAR YEAR DEDUCTIBLE?**	**NETWORK COVERAGE**	**NON-NETWORK COVERAGE**
Reconstructive Surgery After Mastectomy Benefits will be payable on the same basis as any other similarly covered Inpatient Hospital Expense or Medical—Surgical Expense, as shown on the Summary of Benefits.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
OTHER BENEFITS				
Other Medical Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]

Pregnancy Coverage: Benefits are payable for pregnancy-related expenses of female Employees and dependents, including Complications of Pregnancy, on the same basis as any other illness.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following an uncomplicated vaginal delivery; and a minimum of 96 hours following an uncomplicated cesarean delivery. If, after consultation with the attending Physician, a person is discharged earlier, benefits will be payable in accordance with recognized medical standards for that care by a health care provider, a registered nurse or another other appropriate licensed health care provider. The post delivery care may be provided at the women's home (at her option), a health care provider's office, a health care facility or another appropriate location. Charges for such post-delivery home visits will be paid at 100% and will not be subject to any Calendar Year Deductible.
- Authorization of the first 48 hours of such confinement following an uncomplicated vaginal delivery or the first 96 hours of such confinement following an uncomplicated cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, Your Physician, or other health care provider may obtain such authorization by calling the number shown on Your ID Card.

Pregnancy-related expenses are not subject to any Preexisting Condition limitation.

PREEXISTING CONDITION PROVISION

A "preexisting condition" is an injury or disease for which a person:
received treatment or services; or
took prescribed drugs or medicines;

during the[90 days] immediately preceding the person's effective date of coverage (or, if the Plan requires You to serve a probationary period, the [90 days] immediately preceding the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Policy and Certificate, whichever applies, to determine a person's effective date of coverage.

For the first [365] days following such date, Covered Services do not include any expenses for treatment of a preexisting condition.

[With respect to a Late Enrollee, a preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment. For the first 18 months after a Late Enrollee's enrollment date, Covered Services do not include any expenses for treatment of a preexisting condition.]

Special Rules As To A Preexisting Condition:

If a person had creditable coverage, then the preexisting limitation period under this Plan will be reduced by the number of days of prior creditable coverage.

As used above: "continuous creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Members' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED

We will not treat genetic information as a preexisting condition in the absence of a diagnosis of the condition related to the information.

LIMITATIONS:

Not covered are charges for a service or supply furnished by a Participating Provider that exceeds the negotiated charge agreed to by Participating Providers.

Explanation of Some Important Plan Provisions

Network and Non-Network Coverage Year Deductible
This is the amount of Network and Non-Network care, and other health care Covered Services You pay each Calendar Year before benefits are paid.
Network and Non-Network Care Family Coverage Year Deductible Limit
This limit applies to all Covered Services incurred for Network, Non-Network Care, and other health care by the Employee or his/her covered dependents. After that limit is reached, the Employee and his/her covered dependents will be deemed to have met separate Network and Non-Network coverage year Deductibles. The Network and Non-Network Family Coverage Year Deductible Limit is shown in the Summary of Benefits.

COVERED SERVICES

1. HOSPITAL INPATIENT FACILITY EXPENSES

Benefits are available for supplies, room and board, and non-Physician services received during the inpatient stay. Included are charges for services (non-Physician) made in connection with room occupancy. Benefits for Physician services are described under the section titled Physician Inpatient Services.

2. PHYSICIAN INPATIENT SERVICES (SURGICAL AND NON-SURGICAL)

Covered Services include the following charges made by a Physician:

Inpatient surgical and non-surgical services as follows:

1. Surgical services are the services of the operating Physician in performing a surgical procedure. This includes: The usual and related preoperative care; the administering of an anesthetic; the usual and related postoperative care.
2. Surgical assistance services are the services of a Physician in giving needed technical assistance to the operating Physician during a surgical service for which a benefit is paid under this Plan. No benefit is paid if such assistance is routinely done as a service by an intern; a resident Physician; or a house officer of a Hospital.
3. Anesthesia services are the services of a Physician in administering an anesthetic when a surgical services benefit is paid under this Plan. No benefit is paid if the anesthetic is administered by the operating Physician or his or her assistant.
4. Non-surgical medical treatment given to a Covered Person while confined as an inpatient in a Hospital, treatment facility, Inpatient Rehabilitation Facility, Convalescent Facility, Skilled Nursing Facility, or Hospice Facility and for consultation services given to a Covered Person while confined as an inpatient in such facility. Consultation services must be asked for by the attending Physician. A "consultation" is an exam of the Covered Person, a review of his or her x-ray and lab exams, and a review of the Covered Person's medical history. It will include a written report by the consulting Physician if the attending Physician requests one.

   No benefits are paid for consultation services:
   a. If the consulting Physician performs surgery as a result of the consultation.
   b. For staff consultations required by a facility.

3. OUTPATIENT SURGERY, DIAGNOSTIC/THERAPEUTIC AND THERAPEUTIC SERVICES

A. OUTPATIENT SURGICAL SERVICES

This benefit pays for Covered Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Surgeries performed in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

B. OUTPATIENT DIAGNOSTIC SERVICES

When ordered by a Physician, this benefit pays for Covered Services received on an outpatient basis at a Hospital or Alternate Facility for lab and radiology/x-ray, mammograms, bone mass measurement services, pap test, prostate cancer examination and testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, benefits are described under the Doctor's Office Visits Services below. It does not include CT Scans, PET Scans, MRI's, or nuclear medicine.

C. OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES-CT SCANS, PET SCANS, MRI AND NUCLEAR MEDICINE

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Diagnostic Services performed for CT Scans, PET Scans, MRI's, and Nuclear Medicine in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

D. OUTPATIENT THERAPEUTIC TREATMENTS

This benefit includes Covered Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge required for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Doctor's Office, benefits are described under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

4. PRIMARY CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)

We will pay for Covered Services received in a Primary Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Primary Care Doctor specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

5. SPECIALIST CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)

We will pay for Covered Services received in a Specialist Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Specialist Care Doctor is a Doctor who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

6. URGENT CARE CLINIC VISITS (NON-SURGICAL)

We will pay for Covered Services received in an Urgent Care Clinic for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Urgent Care Clinic Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

An Urgent Care Clinic provides services at a facility, other than a Hospital, and provides Covered Services that are required to prevent serious deterioration of the Covered Person's health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

7. INJECTIONS RECEIVED IN A DOCTOR'S OFFICE

Benefits are paid under this benefit for injections received in a Physician's office when no other health service is received.

Childhood immunizations are paid under the Routine Preventive Care Expenses benefit.

8. MATERNITY SERVICES

Benefits for Pregnancy will be paid at the same level as Covered Services for any other condition, Illness, or Injury. This includes all maternity related services for prenatal care, postnatal care, delivery, and any related complications. We will pay Covered Services for an Inpatient say of at least: 48 hours for the mother and newborn child following a normal vaginal delivery; 96 hours for the mother and newborn child following a cesarean section delivery.

9. HOSPICE CARE EXPENSES

Charges made for the following furnished to a person for Hospice Care when given as a part of a Hospice Care Program are included as Covered Services.

Facility Expenses
The charges made in its own behalf by a:

1. Hospice Facility;
2. Hospital;
3. Convalescent Facility;

which are for:
Board and room and other services and supplies furnished to a person while a full-time inpatient for:

1. pain control; and
2. other acute and chronic symptom management.

Not included is services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses

- Charges made by a Hospice Care Agency for:
  1. Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day.
  2. Medical social services under the direction of a Physician. These include assessment of the person's:
     i. social, emotional, and medical needs; and
     ii. the home and family situation;
     iii. identification of the community resources which are available to the person; and
     iv. assisting the person to obtain those resources needed to meet the person's assessed needs.
  3. Psychological and dietary counseling.
  4. Consultation or case management services by a Physician.
  5. Physical and occupational therapy.
  6. Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
  7. Medical supplies.
  8. Drugs and medicines prescribed by a Physician.
- Charges made by the providers below, but only if the provider is not an Employee of a Hospice Care Agency; and such agency retains responsibility for the care of the person.
  1. A Physician for consultant or case management services.
  2. A physical or occupational therapist.
- Not included are charges made:
  1. For bereavement counseling.
  2. For funeral arrangements.
  3. For pastoral counseling.
  4. For financial or legal counseling. This includes estate planning and the drafting of a will.
  5. For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
  6. For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

10. HOME HEALTH CARE EXPENSES

Home health care expenses are Covered Services if:
1. the charge is made by a Home Health Care Agency; and
2. the care is given under a Home Health Care Plan; and
3. the care is given to a Covered Person in his or her home; and
4. the Covered Person is homebound.

Home health care expenses include charges for:
1. Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
2. Part-time or intermittent home health aide services for patient care when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
3. Physical, occupational, and speech therapy.
4. Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.

The following to the extent they would have been covered under this Plan if the Covered Person had been Hospital confined:
1. medical supplies;
2. drugs and medicines prescribed by a physician; and
3. lab services provided by or for a home health care agency.

Home health care expenses do not include charges incurred for:

1. Services or supplies that are not a part of the Home Health Care Plan.
2. Services of a person who usually lives with a Covered Person or who is a member of the Covered Person's spouse's family.
3. Services of a social worker.
4. Transportation.
5. Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
6. Services that are custodial care. However, if the Covered Person is a minor or an adult who is dependent upon others for custodial care, coverage will be provided during times when there is a family member or caregiver present in the home to meet the Covered Person's custodial care needs. Coverage for home health care expenses is not determined by the availability of providers to provide care or services. The absence of a provider to perform a custodial care service does not cause the service to become a covered medical expense.

11. SPINAL DISORDER TREATMENT BENEFIT

Covered Services include charges incurred for:

1. manipulative (adjustive) treatment; or
2. other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Maximum Visits per Coverage Year will be payable for all expenses incurred in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full time inpatient in a Hospital
- for treatment of scoliosis
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating Physician.

12. ROUTINE PREVENTIVE CARE EXPENSES

Covered Services include charges made by a Physician for preventive care exams performed on a Covered Person for a reason other than to diagnose or treat a suspected or identified injury or disease.

Included as a part of the exam are:

1. X-rays, lab, and other tests given in connection with the exam; and
2. materials for the administration of immunizations for infectious disease and testing for tuberculosis.

Covered expenses for routine preventive care provided under this benefit include, but are not limited to, those charges made for:

1. Physical exams.
2. Cytological screening.
3. Colon cancer examinations and laboratory tests for:
   a. Covered persons who are fifty (50) years of age or older;
   b. Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
   c. Covered persons experiencing the following symptoms of colorectal cancer as determined by a licensed physician:
   (1) Bleeding from the rectum or blood in the stool; or
   (2) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days;
4. Prostate specific antigen tests and digital rectal exams.

5. Bone mass density measurements.
6. Mammograms
   a. A baseline mammogram for a woman covered by such a policy who is thirty-five (35) to forty (40) years of age;
   b. A mammogram for a woman covered by such a policy who is forty (40) to forty-nine (49) years of age, inclusive, every one (1) to two (2) years based on the recommendation of the woman's physician;
   c. A mammogram each year for a woman covered by such a policy who is at least fifty (50) years of age;
   d. Upon recommendation of a woman's physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer; and
   e. Insurance coverage for screening mammograms will not prejudice coverage for diagnostic mammograms as recommended by the woman's physician.

   We will not pay for mammography's performed in an unaccredited facility.
7. Routine Pap Smears

   Covered Services include charges incurred for:
   a. one routine gynecological exam each Calendar Year; and
   b. an annual routine Pap smear.

Mammography means radiography of the breast.

Screening mammography is a radiological procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two (2) views of each breast and includes a physician's interpretation of the results of the procedure.

Not included under this benefit are any exams; or other preventive services and supplies; which are specifically covered elsewhere in this Plan. The most that will be paid for all covered routine preventive care expenses incurred by a Covered Person in a Calendar Year under this benefit is the Routine Preventive Care Maximum.

13. PRIVATE DUTY NURSING EXPENSES

The charges of a:
1. R.N;
2. L.P.N.; or
3. nursing agency;

for private duty nursing provided on an inpatient or outpatient basis are deemed Covered Services.

No other charges made by an R.N. or L.P.N. or a nursing agency for private duty nursing are covered.

Not included as private duty nursing is:
1. that part or all of any nursing care that We determine does not require the skills of an R.N.; or
2. any nursing care given while the Covered Person is an inpatient in a health care facility, that could safely and adequately be furnished by that facility's general nursing staff if it were fully staffed.

14. PROSTHETIC DEVICES

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Doctor. Except for items required by the Women's Health and Cancer Rights Act of 1998, benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Except for items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Non-Network benefits for prosthetic devices is limited to $500 per Calendar Year. This limit applies to the total amount that We will pay for the prosthetics, and does not include any copayment or annual deductible responsibility the insured may have. Once the benefit limit is met, no additional benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.

15. REHABILITATION SERVICES – OUTPATIENT THERAPY

Benefits covered under this provision include short-term outpatient rehabilitation services for:

- Physical Therapy.
- Occupational Therapy.
- Speech Therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Doctor.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the condition of the insured within two months of the start of treatment.

Please note: We will pay benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke, or a congenital anomaly.

16. DURABLE MEDICAL EQUIPMENT

Covered Services for Durable Medical Equipment must meet the following criteria:

- Ordered or provided by a Physician for outpatient use;
- Used for medical purposes;
- Not consumable or disposable;
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost effective piece of equipment.

Durable Medical Equipment also includes hearing aids for a covered child under the age of eighteen if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a Physician and an audiological evaluation medically appropriate to the age of the child.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

We provide benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years. We will decide if the equipment should be purchased or rented. To receive Network benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify.

17. AMBULANCE SERVICE EXPENSES

This Plan pays the charges made by a professional ambulance service for:

1. the necessary air; water; or ground; transport of a Covered Person from the place where he or she has sustained an injury or is stricken by a disease to the nearest Hospital where treatment is given; and
2. the necessary non-emergency transfer of a Covered Person via ground ambulance or medical van.

Not covered are any charges made to transfer the Covered Person:

1. if ambulance service is not required by the Covered Person's physical condition;
2. if the type of ambulance service provided is not appropriate for the Covered Person's physical condition; and
3. via any form of transportation other than a professional ambulance service.

18. EMERGENCY ROOM SERVICES

We will pay for Covered Services incurred for Emergency Care due to an Illness or Injury for services Medically Necessary that do not result in Hospital Confinement. Emergency room benefits for an Illness will be paid for a Covered Person but will not exceed the overall Calendar Year maximum shown in the Summary of Benefits.

ADDITIONAL BENEFITS

1. Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:
a. All stages of the reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Benefits will be payable on the same basis as any other similarly covered Inpatient Facility Expense or medical-surgical Expense, as shown on the Summary of Benefits.

Prohibitions: We may not (a) offer the Covered Person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any Covered Person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the Physician or provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or provider to provide care to a Covered Person in a manner inconsistent with the coverage and/or benefits shown above.

Other Medical Expenses

1. Covered Services include charges incurred by a Covered Person for equipment, supplies and outpatient self-management training and education for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

   Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthodics.

   Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician includes:
   a. visits medically necessary upon the diagnosis of diabetes;
   b. visits under circumstances whereby a Physician identifies or diagnoses a significant change in the Covered Person's symptoms or conditions that necessitates changes in a Covered Person's self-management; and
   c. visits where a new medication or therapeutic process relating to the Covered Person's treatment and/or management of diabetes has been identified as medically necessary by a Physician.

2. Formulas that are equivalent to a prescription drug necessary for the therapeutic treatment of rare hereditary genetic metabolic disorders. As used in this provision: Rare hereditary genetic metabolic disorders are phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

3. The following charges when incurred by a Dependent child are included as Covered Services even though not incurred in connection with the treatment of a disease or injury.

   Children's Preventive Health Care Services

   Physician-delivered or physician-supervised services for eligible dependents from birth through age eighteen (18) years of age, with Periodic Preventive Care Visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section.

   Periodic Preventive Care Visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice, provided at the following age intervals:

   A. Birth;
   B. Two (2) weeks;
   C. Two (2) months;
   D. Four (4) months;
   E. Six (6) months;
   F. Nine (9) months;
   G. Twelve (12) months;
   H. Fifteen (15) months;
   I. Eighteen (18) months
   J. Two (2) years;
   K. Three (3) years;
   L. Four (4) years;
   M. Five (5) years;
   N. Six (6) years;
   O. Eight (8) years;
   P. Ten (10) years;
   Q. Twelve (12) years;
   R. Fourteen (14) years;
   S. Sixteen (16) years; and
   T. Eighteen (18) years.

   Benefits for recommended immunization services are payable at 100% with no deductible, copayment, coinsurance or maximum limit.

4. Covered Services include charges incurred for outpatient In Vitro Fertilization expenses, even though not incurred for treatment of a disease or injury by a female employee or by the dependent wife of a male employee. Expenses incurred for cryo preservation are also included.

   Benefits are provided on the same basis as any other illness if all of the following tests are met:
   a. The procedures are performed while she is not confined in a hospital or any other facility as an inpatient.
   b. Her oocytes are fertilized with her husband's sperm.
   c. She and her husband have a history of infertility which has lasted at least 2 years or the infertility is associated with one or more of these conditions.
      1) Endometriosis;
      2) Exposure in utero to diethylstilbestrol; known as DES;
      3) Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy; or
      4) Abnormal male factors contributing to the infertility.
   d. She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
   e. The in vitro fertilization procedures are performed:
      1) at a medical facility licensed or certified by the Arkansas Department of Health; or
      2) certified by the Arkansas Department of Health as either:
         a) meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
         b) meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

   Not more than the In Vitro Fertilization Maximum will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

5. Covered Services include charges incurred the necessary care and treatment of loss or impairment of speech or hearing payable on the same basis as any other illness.

   Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

   Coverage is not provided for hearing instruments or devices.

6. Mastectomy or Lymph Node Dissection

   Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:
   a. 48 hours following a mastectomy; and
   b. 24 hours following a lymph node dissection.

   The minimum number of inpatient hours is not required if the Covered Person receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

   Prohibitions: We may not (a) deny any Covered Person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any Covered Person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Covered Person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management Program uses the services of a Utilization Management Company to determine whether Covered Services are Medically Necessary. It is the Covered Person's responsibility to read and understand this benefit. The Covered Person should ask the Policyholder about how this program works.

The Utilization Management Program requires the cooperation of the Covered Person, Doctors, Providers, and Us. This program consists of medical review, medical case management, and mental illness and substance abuse reviews.

All Participating Providers have agreed to participate in the Utilization Management Program. This does not relieve the Covered Person of his responsibility to comply with all of the requirements of the Utilization Management Program.

For Your assistance in contacting the Utilization Management Company , a toll-free number has been placed on Your I.D. Card.

Following the review, the Utilization Management Company will issue written documentation to the Provider and the Covered Person which specifies the conditions of the authorization. Any payments for Covered Services are subject to all the terms and conditions of the Plan.

The ultimate decision as to whether any care should be received is between the Covered Person and the Doctor. If the Covered Person chooses to enter the Hospital or receive treatment without obtaining pre-authorization. Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of benefits will be reduced by 50%.

The Utilization Management Company may suggest the use of alternate forms of treatment or facilities which are not covered under the Plan. When this occurs, subject to Our approval, these expenses will be covered under the Plan on the same basis as the care and treatment for which they are substituted.

MEDICAL REVIEW PROGRAM

All Hospital admissions are subject to pre-authorization by a Utilization Management Company (UMC) selected by Us, and it is the Covered Person's responsibility to comply with all of the requirements of this program unless the Covered Person receives covered services from a Network Provider in which case it is the Network Provider's responsibility to notify the Utilization Management Company (UMC) for certification of a Hospital admission.

The Doctor, the Covered Person, or a member of his family must notify this organization as follows:

- Prior to a non-emergency admission;
- Within 24 hours, or on the first business day following an emergency admission.

The Utilization Management Company will review the applicable information and authorize:

- The Hospital admission, if it is Medically Necessary;
- The appropriate initial length of stay;
- Any extension beyond the original length of stay if it is Medically Necessary;
- An alternative course of treatment.

If pre-authorization is obtained, Eligible Expenses will be paid the same as any other Illness.

If pre-authorization for Hospital admissions is not obtained as stated above, benefits will be reduced after the Deductible Amount has been satisfied. Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of Benefits will be reduced by 50%. Note, if the Network Provider fails to obtain certification from the Utilization Management Company, no penalty may be assessed the Covered Person.

MEDICAL CASE MANAGEMENT

Medical Case Management is intended to improve the effectiveness of health care by monitoring patient treatment plans and working directly with Doctors and patients to optimize care.

Medical Case Management is indicated only for patients who have diagnoses which typically require expensive or prolonged treatment, and which can frequently be optimized through a personal assessment. It takes physical, clinical, and psychosocial factors into consideration during the process.

Once a patient is determined to be a candidate for Medical Case Management, a case manager may perform any or all of the following:

1)Establish a working relationship with the patient's Doctors and other members of the health care team to assess the patient's needs;

2)Identify cost effective alternatives for treating the patient;

3)Develop a treatment plan that can maximize the patient's level of functioning.

SECTION 4: DESCRIPTION OF NETWORK AND NON-NETWORK BENEFITS

This section includes information about:

• Network Benefits.
• Non-Network Benefits.
• Emergency Care Services.

NETWORK BENEFITS

Network benefits are generally paid at a higher level than Non-Network benefits. Network benefits are payable for Covered Services which are either of the following:

- Provided by or under the direction of a Network Physician or other Network Provider in the Physician's office or at a Network facility.
- Emergency Care Services.

COMPARISON OF NETWORK AND NON-NETWORK BENEFITS

- Network benefits offer a higher level of benefits which means less cost to You. See the Summary of Benefits.

- Non-Network benefits offer a lower level of benefits which means more cost to You. See the Summary of Benefits.

WHO SHOULD FILE CLAIMS

Network

Not required. We pay Network Providers directly.

Non-Network

You must file claims. See Section: How to File a Claim.

PROVIDER NETWORK

Network Providers are independent practitioners. They are not Our Employees. It is Your responsibility to select Your Provider.

Before obtaining services You should always verify the Network status of a Provider. A Provider's status may change. You can verify the Provider's status by contacting customer service.

It is possible that You might not be able to obtain services from a particular Network Provider. The network of Providers is subject to change. Or You might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network benefits.

DESIGNATED FACILITIES AND OTHER PROVIDERS

A. If Your Physician is a Network Provider, the Network Provider will notify Us of situations that might warrant a move to a designated facility or Non-Network facility or Provider if:
   1. You have a medical condition requiring special service needs (including, but not limited to, transplants or cancer treatment); or
   2. You require certain complex Covered Services for which expertise is limited;

   Benefits will be paid at the Network level.

B. If your Physician is a Non-Network Provider, it is Your responsibility to make sure we are notified of the above situations. If We are not notified in advance and if You receive services from a Non-Network facility (regardless of whether it is a designated facility) or other Non-Network Provider, Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of Benefits for Non-Network Benefits will be reduced by 50%. Non-Network Benefits will be available if the special needs services You receive are Covered Services for which Benefits are provided under the Policy.

HEALTH SERVICES FROM NON-NETWORK PROVIDERS PAID AS NETWORK BENEFITS

If specific Covered Services are not available from a Network Provider, You may be eligible for Network Benefits when Covered Services are received from Non-Network Providers. In this situation, Your Network Physician will notify Us, and we will work with You and Your Network Physician to coordinate care through a Non-Network Provider. If we authorize care through the Non-Network Provider, benefits would be paid as if the services were received from a Network facility or provider.

CONTINUITY OF CARE

If You are under the care of a Network Provider for one of the medical conditions below, and the Network Provider caring for You is terminated from the Network by Us, we can arrange, at Your request and subject to the Provider's agreement, for continuation of Covered Services rendered by the terminated Provider as a Network Benefit.. Medical conditions and time periods for which treatment by a terminated Network Provider will be covered under the Plan as a Network Benefit are:

- A life-threatening illness. Treatment by the terminated Provider may continue as a Network Benefit until the course of treatment is complete, not to exceed three months from the effective date of termination.
- A high risk Pregnancy or a Pregnancy that is past the twenty-fourth week of Pregnancy. Treatment by the terminated Provider may continue as a Network Benefit until the postpartum services related to the delivery are complete. For the purposes of this section "life-threatening illness" means a severe, serious, or acute condition for which death is probable.

This section does not apply when:
- The reason for such termination is due to suspension, revocation, or applicable restriction of the health care Provider's license to practice in this state, or for another documented reason related to quality of care.
- You choose to change health care Providers.
- You move out of the geographic service area of the health care Provider.
- You require only routine monitoring for a chronic condition but is not in an acute phase of the condition.

NON-NETWORK BENEFITS

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Services which are either of the following:

- Provided by Non-Network Providers.
- Provided under the direction of a Non-Network Physician at a Non-Network facility or program.

PRE-AUTHORIZATION REQUIREMENT

You must obtain prior authorization from Us before getting certain Covered Services from Non-Network Providers. For more information please contact customer service

Prior authorization does not mean Benefits are payable in all cases. Coverage depends on the Covered Services that are actually given, Your eligibility status, and any benefit limitations.

NON-NETWORK EMERGENCY CARE SERVICES

Subject to the Deductible, we will provide Benefits for Emergency Care Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Care Services, even if the services are provided by a Non-Network Provider. Emergency Care services will be provided as a Network Benefit until the Insured can be reasonably be expected to be transferred to Network Provider. If You are confined in a Non-Network Hospital after You receive Emergency Care Services, we request notification within one business day or on the same day of admission if reasonably possible. No penalty will be assessed the Covered Person if notification is not given within these time frames if it is shown that it was not reasonably possible to do so. In any event, notification should be provided to Us as soon as is reasonably possible. We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date we decide a transfer is medically appropriate, Non-Network Benefits will be available if the continued stay is determined to be a Covered Service.

EMERGENCY CARE SERVICES includes a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is necessary to determine whether a medical emergency condition exists; necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and services originating in a Hospital emergency facility following treatment or stabilization of an emergency medical condition.

SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS

Services and supplies are not covered if they are:

1. not Medically Necessary;
2. in excess of the Maximum Allowable Charge;
3. not prescribed, recommended or approved by a Physician;
4. not furnished within the scope of the Physician's license;
5. furnished while the person is not a Covered Person by the Policy;
6. provided to the Covered Person or insurer with no legal obligation to pay;
7. furnished by a government plan or facility, unless the Covered Person is legally obligated to pay (except Medicaid and mental health benefits and mental retardation benefits provided by a tax supported institution);
8. for Custodial Care solely for personal needs, comfort or convenience of the Covered Person;
9. to control the Covered Person's environment;
10. provided by the immediate family;
11. provided mainly for education, training or vocational rehabilitation or counseling; or
12. not specifically included as a Covered Service or specifically excluded as not covered by the Plan.

Benefits are not provided for Expenses incurred from:

1. Injury or Sickness:
   a. arising out of or in connection with employment or occupation for wage or profit;
   b. covered or eligible for coverage under Workers' Compensation or any occupational disease, employer's liability or similar law,
   c. caused by an act of declared or undeclared war;
   d. occurring while on active duty with any military, naval or air force of any country or international organization, except this will not apply to orders for active service for training purposes of two month or less;

   e. resulting from the Covered Person's participation in an assault or felony, or while engaged in an illegal occupation;
   f. resulting from intentionally self-inflicted Injury, suicide or attempted suicide;
   g. resulting from voluntary taking of any gas or poison or voluntary taking of any drug, sedative, or narcotic unless prescribed by a Physician and taken according to the prescribed dosage;
   h. resulting from driving a motor vehicle while legally intoxicated according to the laws of the state where the Injury occurs;
   i. occurring while outside of the United States;

2. Procedures or devices that are:
   a. in a research or experimental stage;
   b. considered as experimental or investigational by the protocol of the U. S. Department of Health and Human Services or any of its agencies;
   c. not generally accepted as effective treatment by the U. S. medical community;
   d. primarily used in a laboratory or research setting that has progressed to only limited human use; or
   e. not of demonstrated value for the diagnosis and treatment of an Injury or Sickness;

3. Drugs and medicines that are:
   a. not prescribed by a Physician, or that are not approved by the U. S Food and Drug Administration;
   b. over-the-counter medications of any kind except for medications for the treatment of diabetes;
   c. nutritional supplements, minerals and vitamins, such as, but not limited to, pre-natal vitamins. This exclusion does not apply to formulas for the therapeutic treatment of rare hereditary genetic metabolic disorders;
   d. growth hormones;
   e. determined to be "less than effective" by the Drug Efficiary Study Implementation (DESI) Program;
   f. fertility agents;
   g. for cosmetic use including, but not limited to Retin-A for a Covered Person age 25 and over;
   h. anti-smoking aids, such as, but not limited to, Nicorette Gum;
   i. Dexadrine for a Covered Person over the age of 18;
   j. used to treat or cure baldness, such as, but not limited to, Rogaine or Monoxidil; or
   k. outpatient prescriptions;

4. Hospital admission from Friday 8:00 A.M. through Monday 12:01 A.M. unless surgery is performed within 24 hours of the admission, or because of an emergency;

5. Hospital Confinement that is not Medically Necessary and is solely for the convenience of the Covered Person or Physician;

6. Cosmetic surgery, which term includes but is not limited to:
   a. surgery to the upper and lower eyelid;
   b. augmentation mammoplasty;
   c. full or partial facial lifts;
   d. dermal or chemo abrasion;
   e. scar revision;
   f. otoplasty;
   g. lift, stretch or reduction of abdomen, buttocks, thighs or upper arm;
   h. silicone injections to any part of the body; and
   i. rhinoplasty;

   unless such surgery is required for a condition resulting from congenital defects or birth abnormalities of a newborn child or from Injury, and (except for a newborn child) such Injury occurred while the Covered Person was insured under the Plan;

7. Dental services or supplies, except for the following procedures:
   a. to repair damage to sound natural teeth Accidentally injured while the person is a Covered Person and the repair is done within 12 months from the date of the Injury;
   b. to remove impacted, unerupted teeth;
   c. Reconstructive Surgery for Craniofacial Abnormalities for dependent children under age 18; and
   d. Anesthesia and dental care in a hospital or ambulatory surgical center for a covered person for which the provider treating the patient certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and who:
      (1) is a child under age seven who is determined by two licensed dentists, to require without delay necessary dental treatment for a significantly complex dental condition; or
      (2) is a person with a diagnosed serious mental or physical condition; or
      (3) is a person with a significant behavioral problem as determined by the Covered Person's physician.

8. Eye exams, testing for refraction, eye or visual exercises, vision therapy, or contact lenses or eyeglasses;

9. Radial keratotomy or other surgery to correct or change refractive defects of the eye;

10. Injury resulting from travel, flight in, or descent from any aircraft owned or leased by the Covered Person, or being in any aircraft being used for one or more of the following:
    a. test or experimental purposes;
    b. speed test;
    c. exhibition or stunt flying;
    d. crop dusting or seeding;
    e. hunting, herding or herd thinning; or
    f. fire fighting;

11. Injury while riding in or on a motorized vehicle of any type designed for or primarily used for racing, speed tests, or hazardous exhibition purposes;

12. Injury while engaging in any of the following hazardous activities:
    a. hang gliding or flying an ultra light aircraft;
    b. skydiving; or
    c. scuba diving;

13. Services or supplies for:
    a. diagnosis and testing of fertility or infertility other than In Vitro Fertilization;
    b. reversal of sterilization procedure; or
    c. artificial insemination;

14. Transsexual surgery or other sex modification procedures and any related complications;

15. Marriage counseling and any therapy or counseling for sexual dysfunctions;

16. Weight loss treatment or supplies of any kind, including but not limited to:
    a. gastric bypass, gastroplasty, or gastric stapling, regardless of Physician's recommendation for medical necessity;
    b. balloon catheterization;
    c. diet or exercise programs;
    d. weight reduction programs or clinics; or
    e. liposuction or reconstructive surgery other than reconstructive surgery for Mastectomy and Craniofacial Abnormalities;

17. Exercise equipment or programs regardless of their purpose;

18. Purchase of home based artificial kidney equipment;

19. Treatment or supplies of any kind for routine foot care for (except with respect to diabetic care):
    a. paring or removal of corns, calluses or toenails;
    b. instability or imbalance of the feet; or
    c. orthopedic shoes, orthoses and other supportive devices for the feet, except if needed for conditions resulting from diabetes;

20. Acupuncture, acupressure or massage therapy;

21. Charges for failure to keep an appointment, or to complete claims forms;

22. Hospital confinement for physical therapy, rehabilitation, diagnostic x-ray and laboratory services or other diagnostic studies, except when such care or services cannot be rendered on an outpatient basis;

23. Charges for biofeedback services;

24. Charges for any maintenance type therapy not reasonably expected to improve the patient's condition;

25. Charges for:
    a. any service or supply in connection with an organ transplant, except a human to human organ transplant;
    b. any transplant which is sold rather than donated to the Covered Person; or
    c. any service or supply in connection with autologous bone marrow transplantation for treatment of any disease other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, and neuroblastomas;

26. Treatment, services or supplies for any of the following except if described as a Covered Service by the Policy:
    a. Home Health Care;
    b. abortion unless the life of the mother would be threatened if the fetus were carried to term;
    c. pre-employment or pre-marital examinations;
    d. in vitro, in ovum fertilization or Gamete Intrafallopian Transfer (GIFT);
    e. hearing aids, implants, their fitting, and related hearing tests and exams.

27. Breast reductions are excluded regardless of the Physician's recommendation of Medical Necessity except in connection with Breast Reconstructive Surgery after a covered mastectomy; or

28. In connection with a Genetic Test or chromosome analysis.

29. Charges for a Pre-Existing Condition, except as provided in the Covered Services section of the Plan.

30. Osteotomies, chelation therapy and orthomolecular medicine.

SECTION 6: TERMINATION OF COVERAGE

Termination of the Policy: The Policyholder may terminate the Policy by providing written notice to Us at least 30 days prior to termination. We may terminate the Plan on any date if:

1. The Policyholder fails to pay the premiums as required by the terms of the Plan;
2. The Policyholder has committed fraud or intentional misrepresentation of a material fact;
3. On the first renewal date following the end of a six month consecutive period during which the qualifying minimum participation requirement was not met; or;
4. The Policyholder fails to meet the required contribution requirements.

Termination of Covered Persons:

For the Employee, insurance terminates on the earliest of the following:

1. The date the Plan terminates;
2. The date any benefit of the Plan terminates, in regard to that benefit;
3. The date the Employee cancels insurance;
4. The date the Policyholder cancels insurance for the Employee. The Policyholder must give advanced written notice at least 31 days prior to the date the insurance ends;
5. The date premiums are not paid when due, subject to the Grace Period provision;
6. The date the Employee's employment is terminated;
7. The date the Employee enters full-time military service. For purposes of this insurance, active military service for training purposes of two months or less is not full-time service; or
8. The date the Employee commits fraud upon Us or intentionally misrepresents a material fact which affects his coverage under the Plan.

For the insured **Dependent**, insurance terminates of the earliest of the following:

1. The date the Employee's coverage terminates;
2. The date any benefit of the Plan terminates for the insured Dependent, in regard to that benefit;
3. The date the Employee cancels the insured Dependent's insurance;
4. The date the Policyholder cancels insurance for dependents. The Policyholder must give advanced written notice at least 31 days prior to the date the insurance ends;
5. The date premiums are not paid when due for the insured Dependent, subject to the Grace Period provision;
6. The date the insured Dependent no longer meets the definition of Dependent except that coverage for a grandchild will not terminate solely because grandchild is no longer a Dependent of the Employee for federal income tax purposes.
7. With respect to the Employee's spouse, the date the Employee is divorced from such spouse;
8. The date the insured Dependent commits fraud upon Us or misrepresents a material fact which affects his coverage under the Plan; or
9. The date the insured Dependent enters full-time military service. For purposes of this insurance, active military service for training purposes of two months or less is not full-time service.

Notwithstanding the above, in the event a Covered Person ceases to be eligible for coverage, and the Policyholder fails to report to Us the termination of coverage of the person at least 30 days prior to the pending termination date, coverage will continue for the Covered Person until the end of the month in the Policyholder notifies Us that the Coverage Person is no longer eligible for coverage. The Policyholder will be liable for all premiums for such coverage.

LIMITED EXTENSION DUE TO TOTAL DISABILITY

A Covered Person's benefits will continue to be payable under the Plan when the Policy terminates, if he;

A. Is Totally Disabled; and
B. Is confined to a Hospital for the disabling Illness or Injury at the date the Policy would otherwise terminate.

Benefits paid under this extension will be paid until the earliest of these dates:

A. The date which is ninety (90) days from the date coverage would have otherwise terminated; or
B. The date the Covered Person is no longer Hospital confined; or
C. The date on which the disabled person's Medical Benefit has reached the applicable maximum under the Plan.

This extension of coverage applies only to the disabled person and no premium is due.

SECTION 7: COORDINATION OF BENEFITS

This section applies if You are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If You are covered by more than one health benefit plan, You should file all claims with each plan.

A. Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

Plan
Any of the following that provides benefits or services for medical care or treatment with which coordination is allowed:

1. Group insurance and group subscriber contracts;
2. uninsured arrangements of group or group-type coverage;
3. group or group-type coverage through HMOs and other prepayment, group practice, and individual practice plans;
4. group-type contracts which are contracts that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.
5. the amount by which group or group-type hospital indemnity benefits exceed $100 per day;
6. the Medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and
7. Medicare or other governmental benefits, except a state plan under Medicaid. That part of the definition of "plan" may be limited to the hospital, medical, and surgical benefits of the governmental program.

Each type of coverage You have in the above categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefits rules, each of the parts shall be treated as a separate Plan.

Plan does not include any of the following:
1. individual or family insurance contracts;
2. individual or family subscriber contracts;
3. individual or family coverage through health maintenance organizations (HMOs);
4. individual or family coverage under other prepayment, group practice, and individual practice plans;
5. group or group-type hospital indemnity benefits of $100 per day or less;
6. school accident-type coverages which cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; and
7. a state plan under Medicaid;
8. plans when, by law, their benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Primary Plan.

A plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A plan is a "primary plan" if either of the following conditions is true:
1. the plan either has no order of benefit determination rules, or
2. it has rules which differ from those permitted by this subchapter.

There may be more than one "primary plan"; or all plans which cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan

A plan which is not a "primary plan." If a person is covered by more than one "secondary plan," the order of benefit determination rules of these sections decide the order in which their benefits are determined in relation to each other. The benefits of each "secondary plan" may take into consideration the benefits of the "primary plan" or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that "secondary plan.

Allowable Expense

The necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

Examples of expenses or services that are not an Allowable Expense include, but are not limited to the following:

1. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
2. The difference between the cost of a private Hospital room and the cost of a semi-private hospital room is not considered an "allowable expense" under this section unless the covered person's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.
3. If You are covered by two or more Plans that provide services or supplies on the basis of usual and customary fees, any amount in excess of the highest usual and customary fee is not an Allowable Expense.
4. When benefits are reduced under a primary plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an "allowable expense." Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.
5. When a plan provides benefits in the form of service, the Reasonable Cash Value of each service will be considered as both an "allowable expense" and a benefit paid.

Claim Determination Period

A calendar year, but it does not include any part of a year during which You are not covered under this Agreement or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed Provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care Providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

B. Order of Benefit Determination Rules

A primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. A secondary plan may take the benefits of another plan into account only when, under this subchapter, it is secondary to that other plan.

In determining the order of benefit, the first of the following rules will applies.

1. The benefits of the plan which covers the person as an Employee, member, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent. There is one exception. If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired Employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.
2. With respect to a dependent child whose parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. As used in this paragraph, the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born. If the plan does not have the rule based upon the parent's birthday, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon gender of the parent will determine the order of benefits.

3. With respect to a dependent child whose parents are separated or divorced, where two or more plans cover the child, benefits for the child are determined in this order:
   a. first, the Plan of the parent with custody of the child;
   b. Then, the Plan of the spouse of the parent with the custody of the child; and
   c. finally, the Plan of the parent not having custody of the child.

   d. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
   e. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (2) of this subsection.
4. With respect to active as related to inactive Employees, the benefits shall be determined in the following order. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's dependent) are determined before those of a plan which covers that person as a laid off or retired Employee (or as that Employee's dependent). If the other Plan does not have this rule; and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. With respect to continuation coverage, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
   a. first, the benefits of a plan covering the person as an Employee, member, or subscriber (or as that person's dependent);
   b. second, the benefits under the continuation coverage.
   c. If the other plan does not have the rule described in subparagraphs a. and b. of this paragraph, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
6. Where none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term.
   a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
   b. The start of a new plan does not include:
      (i) a change in the amount or scope of a plan's benefits;
      (ii) a change in the entity which pays, provides, or administers the plan's benefits; or
      (iii) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
   c. The person's length of time covered under a Plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a member of the group will be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

C. Effect on the Benefits of this Agreement

If we are the Secondary Plan, we may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses.

The difference between the benefits payments that we would have paid had we been the Primary Plan and the benefit payments that we actually paid as the Secondary Plan shall be recorded as a benefit reserve for You. We will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

If there is a benefit reserve, we shall use the benefit reserve recorded for You to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, Your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination.

D. Recovery of Excess Benefits

If we provide Services and Supplies that should have been paid by the primary Plan or if we provide services in excess of those for which we are obligated to provide under this Agreement, we shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We shall have the sole discretion to seek such recovery from any person to, or from whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If we request, You shall execute and deliver to such instruments and documents as we determine are necessary to secure its rights.

E. Right to Receive and Release Information

We, without consent of or notice to You, may obtain information from and release information to any Plan with respect to You in order to coordinate Your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate Your benefits pursuant to this section.

SECTION 8:
THIS PROVISION IS SUBJECT TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) AND ALL SUBSEQUENT LAWS EFFECTING THIS ACT.

This provision applies to a Policyholder with twenty (20) or more Employees on a typical business day during the preceding Calendar Year if group health coverage was provided to Employees.

Introduction

You are receiving this notice because You have recently become covered under a group health plan (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Plan and under Federal Law, You should review the Policy or Certificate of Coverage or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualifying beneficiary". You, Your spouse, and Your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
-

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "Dependent child".

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Policyholder must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or a Dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of an Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability extension of 18 month period of continuation coverage

If Your or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage.

Second qualifying event extension of 18 month period of continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare (under Part A, Part B, or both), or gets divorced or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

SECTION 9: CONTINUATION OF COVERAGE

As an alternative to continuation of coverage under COBRA, the following continuation provisions are available to the following Covered Persons:

- Employees whose coverage ends for any reason other than termination of this policy or termination of the class in which the employee was insured.
- The surviving spouse or divorced spouse of an employee whose coverage would otherwise terminate as a result of the divorce or the death of the employee.

Continuation is not available to:

- Employees whose coverage ends because of failure to pay any required contribution towards the cost of their coverage under the policy.
- Covered Persons who are eligible for Medicare.
- Covered Persons whose coverage is replaced by another group medical plan within 31 days after coverage under this policy terminates.
- Covered Persons who have not been insured for at least three months on the date their coverage under this policy ends.

Continuation of coverage is subject to payment of premium to the Policyholder by the Covered Person. The premium will be the amount of premium the Policyholder would pay for the coverage if the Covered Person was insured under this policy in the absence of this continuation provision, including amounts paid towards premium by the Policyholder and by the employee.

Coverage under this policy may be continued for up to 120 days after the month in which coverage under this policy would otherwise terminate except:

- Covered Persons whose coverage would end as a result of the divorce or death of the employee may continue coverage for up to 15 months after the end of the month in which coverage under this policy would otherwise terminate. Such continuation is subject to the Covered Person paying premium to the Policyholder in advance in three month increments.
- Covered Persons who are pregnant when coverage under this policy would otherwise terminate may continue coverage subject to the Covered Person paying premium to the Policyholder in advance in three month increments. Coverage may be continued for up to six months after the pregnancy ends, or if longer, the end of the second three month period following the three month period in which the pregnancy ends.

A Covered Person is eligible for Conversion at the end of this continuation period.

SECTION 10 – CONVERSION

Any Employee whose insurance under this Policy has been terminated for any reason, including discontinuance of this Policy in its entirety or discontinuance of an insured class will be entitled to have issued by Us an individual policy of health insurance (hereafter referred to as the "converted policy"). This provision only applies to individuals whose coverage terminates at the end of any COBRA or state continuation provision provided in the Policy. The converted policy may provide levels which are substantially similar to those provide under this Policy.

A Employee will not be entitled to have a converted policy issued if termination of the insurance under this Policy occurred for any of the following reasons:

a. the Employee failed to pay any required contribution;

b. any discontinued group coverage was immediately replaced by similar group coverage unless such person was declined coverage under the replacing group coverage; or

c. The person is, or could be, covered for Medicare benefits or similar benefits provided by any state or federal law, similar benefits provided on a group or individual basis or any benefits provided above which, together with the benefits provided under the conversion policy, would result in over-insurance.

Written application for the converted policy must be made and the first premium paid to Us not later than thirty-one (31) days after such termination. The converted policy will be issued without evidence of insurability.

The effective date of the converted policy will be the day following the termination of insurance under this Policy. The converted policy will cover the Employee and any dependents who were covered by this Policy on the date of termination of insurance.

This conversion privilege may be exercised at the Employee’s option at the end of any COBRA or state continuation of coverage provision provided under the group policy and will be available to the following:

1. the surviving spouse, if any, of the Employee with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or

2. the spouse of the Employee with respect to the spouse and children whose coverage terminates because the spouse ceases to be a qualified family member and while the Employee remains insured under the group policy, or

3. a child solely upon termination of the coverage by reason of ceasing to be a qualified family member under the group policy, or

4. the former spouse whose coverage under the group policy terminates by reason of an entry of a valid decree of divorce between the insured and spouse.

SECTION 11: GENERAL PROVISIONS

CALCULATION OF PREMIUM

On the Plan's Effective Date, the monthly premium for coverage on Employees and, if applicable, Dependents will be based on the rates shown on the Policyholder's Application for Insurance under the Plan.

We will have the right to change the premium rates or the basis on which premiums are calculated:

A. On any Plan Anniversary; or
B. On any premium due date; but not before the first Policy Anniversary and not more than once every six (6) months after the first Policy Anniversary.

We will provide written notice of any rate increase to the Policyholder at least sixty (60) days before the date the rate increase is to take effect. The rate then being charged must have been approved by Us. Any time period in which a rate must stay in effect will be shown in the Policyholder's Application.

HOW PREMIUMS ARE PAYABLE

Premiums must be paid in advance to Us at the Home Office in New Orleans, Louisiana. Premiums may also be paid to Our authorized agent in exchange for Our receipt signed by Our Officer and countersigned by the agent as evidence of such payment. Premiums may be paid as indicated on the Application. Upon written request to Us, the mode of premium payments may be changed on any Plan Anniversary with proper adjustments. The payment of any premium will not continue the Plan in force beyond the date the next premium is due, except for Grace Period provision.

GRACE PERIOD FOR PAYMENT OF PREMIUMS

If the Policyholder has not given written notice to Us to cancel the Plan, a Grace Period of at least thirty-one (31) days will be allowed after the due date for the payment of each premium after the first. The Plan will continue in force during this period. If the premium is not paid before the end of the Grace Period the Plan will cease on the last day of the Grace Period. All valid claims will be paid for a loss incurred before the expiration of the Grace Period. A pro-rata premium will be due for the Grace Period.

If, before the end of the Grace Period, the Policyholder gives written notice to Us at Our Home Office that the Plan is to be cancelled, the Plan will terminate on the effective date of such notice. A pro-rata premium will be paid for the period between the date the premium was due and the date the Plan ends.

ASSIGNMENT

The coverage provided hereunder is assignable.

CANCELLATION

All or any part of the coverage provided under the Plan may be cancelled by the Policyholder by mailing to Us written notice at least thirty-one (31) days prior to the cancellation date. If the Policyholder cancels this plan, the coverage will end at 12:00 midnight on the last day of the policy month following the required notice period.

Delivery of written notice by either the Policyholder or Us shall be equivalent of mailing.

CONFORMITY WITH STATE STATUTES

Any provision of the Plan which, on its Effective Date, is in conflict with the statutes of the state in which the Plan was issued is hereby amended to conform to the minimum requirements of such statutes, unless otherwise forbidden by the laws of the state where the Covered Person lives.

INADVERTENT ERROR

The Covered Person will not lose the amount of coverage due to him because of error or failure by the Policyholder:

A. To give the name of a Covered Person who has qualified and made the proper payment for coverage; or
B. To report a change in the amount of coverage shown in the Policy or Certificate.

In the event of the Policyholder fails to report the termination of coverage of any Covered Person, the Policyholder will be liable for a Covered Person's premium from the time the Covered Person is no longer part of the group eligible for coverage until the end of the month in which the Policyholder notifies Us that the Coverage Person is no longer eligible for coverage.

INCONTESTABILITY OF PLAN

We will not contest the Plan after it has been in force for two (2) years, except:
A. For nonpayment of premium; or
B. For fraudulent misstatements or intentional misrepresentation of a material fact by the Policyholder.

No statement made by a Covered Person relating to his insurability will be used to contest his coverage:
A. After his coverage has been in force during his lifetime for two (2) years prior to the contest; and
B. Unless such statement is in writing and signed by him.

LEGAL ACTIONS

No legal action will be brought to recover under the Plan:

A. Until sixty (60) days have elapsed after proof of claim has been filed; or
B. After three (3) years from the end of the time within which proof of claim is required by the Plan.

MODIFICATION CAN BE MADE ONLY BY AN OFFICIAL

Only Our President, Vice-President, the Secretary or an Assistant Secretary can change or waive any provision of the Plan. Any changes must be made in writing. We will not be bound by any promises or representations made by an agent or anyone other than the above.

PLAN AND APPLICATION CONSTITUTE ENTIRE CONTRACT

The Plan, Application of the Policyholder for coverage under the Plan, and the Employee's' Enrollment Forms form the entire contract between the parties. All statements made by the Policyholder or by the Employee will be deemed representations and not warranties. No statement made by the Policyholder, the Employee, or his Dependent will be used in any contest unless a copy of the instrument containing such statement is or has been furnished to the Employee.

PRONOUNS

Masculine pronouns used in the Plan will apply to both sexes.

RECORDS OF THE POLICYHOLDER

The Policyholder will give such data as may be required by Us to provide the coverage. This includes data on Covered Persons becoming covered, changes in the amount of coverage and terminations of coverage. Payroll and other personnel records pertaining to coverage under the Policyholder's Plan will be open for review by Us at any reasonable time. Any additional records of the Policyholder as may have a bearing on the coverage shall also be open for review by Us at any reasonable time. The Covered Person will not lose the amount of coverage due him because of error or failure by the Policyholder:

A. To give the name of a Covered Person who has qualified and made the proper payment for coverage; or
B. To report a change in the amount of coverage shown in the Policy or Certificate.

Failure to report the termination of coverage of any Covered Person will not continue the coverage beyond the date of termination shown in the Policyholder's Plan.

WORKER'S COMPENSATION

The Plan is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.

RIGHT OF SUBROGATION

Subrogation means We have the right to request a refund of payments made by Us under the following conditions:

We will be subrogated to any claim a Covered Person has against a third party provided:

A. The Covered Person was injured or became ill due to the act or omission of the third party, and
B. We paid benefits to the Covered Person under the Plan for such Injury or Illness.

If the Covered Person collects any sums for damages from the third party, the Covered Person will be liable to Us for the benefits We paid. If the Covered Person sues to recover his expenses from a third party, We can join in the suit. If the Covered Person does not sue, We can do so in the name of the Covered Person.

The Covered Person is obligated to:

A. Avoid doing anything that would prejudice Our right of subrogation; and
B. Execute any documents reasonably required to enforce Our right.(Failure to execute the required documents does not waive our rights to collect any sums for damages from the third party.)

SECTION 12: UNIFORM CLAIMS PROVISION

NOTICE OF CLAIM

Written notice of claim must be given to Us within twenty (20) days after the date any Injury or Illness occurs or begins. If notice is not furnished within the time limit stated above, a claim will still be considered for payment and will not be denied or reduced due to the delay if it is shown that notice was given as soon as was reasonably possible.

CLAIM FORMS

We will furnish forms for filing proof of claim after We get the notice of claim. If such forms are not furnished within fifteen (15) days of receipt of the notice, the claimant will be deemed to have met with the terms of this provision of the Plan if he submits written proof of claim within the time set forth in the Proof of Claim provision.

PROOF OF CLAIM

Written proof of claim must be given to Us within ninety (90) days after the date of treatment.

However, the claim will not be denied or reduced if:

1. It is not reasonably possible to give proof in that time; and
2. Proof is submitted within one (1) year from the date of Loss or treatment.

This one (1) year period will not apply when the Covered Person is legally incapable of submitting proof. All proofs of claim must be satisfactory to Us.

TIME PAYMENT OF CLAIMS

We will pay or deny a clean claim within 30 days after receipt if the claim was submitted electronically or within 45 days after receipt if the claim was submitted by other means.

We will notify the insured within 30 days after receipt of the claim if We determine that the claim can be processed.

If We fail to pay or deny a clean claim according to this provision, we will pay a penalty to the insured for the period beginning on the sixty-first day after receipt of the clean claim and ending on the clean claim payment date (the delinquent payment period), calculated as follows: the amount of the clean claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such penalty will be paid without any action by the insured.

PHYSICAL EXAMINATION

We, at Our own expense, will have the right to have a Covered Person examined as often as We may reasonably require, while a claim is pending.

How to File a Claim

This section provides You with information about:
• How and when to file a claim.
• If You receive Covered Services from a Network Provider, You do not have to file a claim. We pay these Providers directly.
• If You receive Covered Services from a Non-Network Provider, You are responsible for filing a claim.

If You Receive Covered Services from a Network Provider

We pay Network Providers directly for Your Covered Services. If a Network Provider bills You for any Covered Health Service, contact Us. However, You are responsible for meeting the Deductible.

If You Receive Covered Services from a Non-Network Provider

When You receive Covered Services from a Non-Network Provider, You are responsible for requesting payment from Us. You must file the claim in a format that contains all of the information we require, as described below.

You must submit a request for payment of Benefits within 90 days after the date of service. If You don't provide this information to Us within one year of the date of service, Benefits for that health service will be denied or reduced, according to the terms of the policy. This time limit does not apply if You are legally incapacitated. If Your claim relates to an inpatient stay, You must request payment of Benefits within 90 days of the date you are released from the Hospital.

We will pay benefits directly to a Physician or other health care provider, and will be relieved of the obligation to pay, and of any liability for paying, those benefits to the Covered Person if:
(1) the Covered Person makes a written assignment of those benefits payable to the Physician or other health care provider; and
(2) the assignment is obtained by or delivered to Us with the claim for benefits.

Required Information

When You request payment of Benefits from Us, You must provide Us with all of the following information:
A. The Covered Person's name and address.
B. The patient's name and age.
C. The number stated on Your ID card.
D. The name and address of the Provider of the service(s).
E. A diagnosis from the Physician.
F. An itemized bill from Your Provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
G. The date the Injury or Sickness began.
H. A statement indicating either that You are, or You are not, enrolled for coverage under any other health insurance plan or program.

If You are enrolled for other coverage You must include the name of the other carrier(s).

Payment of Benefits

You may not assign Your Benefits under the Plan to a non-Network Provider without our consent. We may, however, in our discretion, pay a non-Network Provider directly for services rendered to You.

SECTION 14: CLAIMS AND APPEAL NOTICE

Benefit Determinations

Post-service Claims
Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If Your post-service claim is denied, You will receive a written notice from us within 15 business days of receipt of the claim, as long as all needed information was provided with the claim. We will notify You within this 15 business day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend Your claim until all information is received. Once notified of the extension, You then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is determined to be eligible for payment, the claim will be paid immediately. If the claim is determined not eligible for payment and is denied, we will notify You of the denial within 15 days.

If You do not provide the needed information within the 45-day period, Your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Pre-authorization Requests for Benefits

Pre-authorization requests for Benefits are those requests that require authorization prior to receiving medical care. If You have a pre-authorization request for Benefits, and it was submitted properly with all needed information, You will receive notice of the decision from us. We will mail or otherwise transmit such notice to You and to Your Physician not later than 3 calendar days of receipt of the request. If additional information is needed to process the pre-authorization request, we will notify You of the information needed within 3 calendar days after it was received, and may request a one time extension not longer than 15 days and pend Your request until all information is received. Once notified of the extension You then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify You of a non-adverse determination within 2 working days after the information is received. We will notify You of an adverse determination within 3 working days after the information is received If You don't provide the needed information within the 45-day period, Your request for Benefits will be denied. A denial notice of an adverse determination will include:
(1) the principal reasons for the adverse determination;
(2) the clinical basis for the adverse determination;
(3) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and
(4) a description of the procedure for the complaint and appeal process, including notice to You of Your right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations: • You will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written or electronic confirmation to follow within three days. If You filed an urgent request for Benefits improperly, we will notify You of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify You of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information. You will be notified of a benefit determination no later than 48 hours after:
• Our receipt of the requested information; or
• The end of the 48-hour period within which You were to provide the additional information, if the information is not received within that time. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and Your request to extend the treatment is an urgent request for Benefits as defined above, Your request will be decided within 24 hours, provided Your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on Your request for the extended treatment within 24 hours from receipt of Your request. If Your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and You request to extend treatment in a non-urgent circumstance, Your request will be considered a new request and decided according to post-service or pre-authorization timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If You have a question or concern about a benefit determination, You may informally contact our customer service department before requesting a formal appeal. If the customer service representative cannot resolve the issue to Your satisfaction over the phone, You may submit Your question in writing. However, if You are not satisfied with a benefit determination as described above, You may appeal it as described below, without first informally contacting a customer service representative. If You first informally contact our customer service department and later wish to request a formal appeal in writing, You should again contact customer service and request an appeal. If You request a formal appeal, a customer service representative will provide You with the appropriate address. If You are appealing an urgent claim denial, please refer to the *Urgent Appeals that Require Immediate Action* section below and contact our customer service department immediately.

How to Appeal a Claim Decision

If You disagree with a pre-authorization request for Benefits determination or post-service claim determination after following the above steps, You, your Physician, a person acting on your behalf, or other healthcare provider can contact us orally or in writing to formally request an appeal.
The request should include:
• The patient's name and the identification number from the ID card.
• The date(s) of medical service(s).
• The Provider's name.
• The reason You believe the claim should be paid.
• Any documentation or other written information to support Your request for claim payment. Within five working days from the date We receive the appeal, We will send You a letter acknowledging the date of receipt. The letter will include a list of:
(1) the procedures for appeal; and
(2) the documents that the appealing party must submit for review

When We receive an oral appeal of an adverse determination, We will send a one-page appeal form to the appealing party.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If Your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Upon request and free of charge, You have the right to reasonable access to and copies of all documents, records, and other information relevant to Your claim for Benefits.

Appeals Determinations

Pre-authorization Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on Your appeal as follows:

• For appeals of **pre-authorization requests for Benefits** as identified above, the first level appeal will be conducted and You will be notified of the decision within 3 calendar days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and You will be notified of the decision within 3 calendar days from receipt of a request for review of the first level appeal decision.

• For appeals of **post-service claims** as identified above, the first level appeal will be conducted and You will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and You will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision. For procedures associated with urgent requests for Benefits, see *Urgent Appeals That Require Immediate Action* below. If You are not satisfied with the first level appeal decision, You have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. Please note that our decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between You and Your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:
• The appeal does not need to be submitted in writing. You or your physician should call Us as soon as possible.
• We will provide You with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

SECTION 15:

NMHPA - NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

What are the special rights for childbirth under NMHPA?

Policyholder health plans and health insurers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following an uncomplicated vaginal delivery, or less than 96 hours following an uncomplicated cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). **This Act does not change the benefit limits or Deductibles of the Plan.**

WOMEN'S HEALTH AND CANCER RIGHTS ACT - IMPORTANT MASTECTOMY NOTICE

What are the rights for reconstructive surgery after a mastectomy?

Effective October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act. The Act stipulates that any health plan that provides medical benefits for a mastectomy must also provide coverage for breast reconstruction if the Covered Person chooses to receive it. Specifically, any patient who is covered for mastectomy is also covered for reconstruction of the breast on which the mastectomy was performed, reconstruction of the other breast to achieve symmetry, and prostheses and physical complications of all stages of mastectomy including lymphedema. **This Act does not change the benefit limits or Deductibles of the Plan.**

Employer Application

Requested Effective Date

_____

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. Submit the most recent billing statement listing those currently insured and current status.
3. Submit most recent wage and tax information.
4. Include a deposit check for the first's month's premium.
5. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**

General Information

Group Name		Tax ID
Street Address		Suite
City	State	Zip Code
Contact Person	Telephone ( )	Email Address

Billing Address (if different)	Industry Code
Organization Type ☐ Partnership ☐ Corp ☐ LLC/LLP ☐ Ind. Contractor ☐Non-Profit ☐Other _____	Nature of Business

Multi-Location Group ☐ Yes ☐ No	# of Locations	Address(es) (or, list on additional sheet of paper)

List Names Currently on COBRA/Continuation ☐ See attached list ☐ None	Waiting Period for new hires: 1st of the month following [15/30/60/80/90/180 days of employment]
Have Worker's Comp ☐ Yes ☐ No	List Owners/Partners not covered by Worker's Comp

Waiting Period waived at initial enrollment ☐ Yes ☐ No	# of hours per week to be eligible	Classes excluded ☐ None ☐ Union ☐ Other _____

Participation and Contribution Information

Participation	**# Applying**	**# Waiving**	**Contribution**	
# Full Time Employees:	_____	_____	_____	Employer % _____
# Ineligible Employees:	_____			Employer % for Dep _____
Total # Employees	_____	**Name of Current Carrier** _____		

Benefits

[Deductible:	$1000 Network; $2000 Non-Network
Reimbursement Percentage:	80% Network; 60% Non-Network
Calendar Year Maximum:	$50,000 Inpatient; $5,000 Outpatient]

Health Coverage Provided by Pan-American Life Insurance Company

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

Questions Regarding Group Size	
☐ Cobra	Under federal law, if Your group had 20 or more employees on your payroll on at least 50% of the employer's working days of the preceding calendar year, you must provide employees with COBRA continuation.
☐ Medicare Primary ☐ Plan Primary	Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary.
☐ Yes ☐ No	Are you a member of a "controlled group of corporations" as that term is defined by United States Internal Revenue Code section 414(b). If yes, please give the legal names of all other corporations within the controlled group and the number of employees employed by each.

Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this Application may be transmitted electronically to me and to the Company's employees.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that the Insurer will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences are permitted by law.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature

Employer Signature	Title	Date

Commission Information

Writing Broker Name	Agency/Writing Broker SSN	In Broker appointed with PAL?	
Commissions Payable to:	Payee Code/Tax ID#	If more than 1 Broker % Production ____%	
Street Address	City	State	Zip
Broker Phone # ( )	Broker Email Address	Broker Fax ( )	

The contents of this application were fully explained during a meeting with the Employer submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.

Broker Signature	Date

For the Second Broker / Agent (if applicable)

Writing Broker Name	Agency/Writing Broker SSN	In Broker appointed with PAL?	
Commissions Payable to:	Payee Code/Tax ID#	If more than 1 Broker % Production _____%	
Street Address	City	State	Zip
Broker Phone # ( )	Broker Email Address	Broker Fax ( )	

The contents of this application were fully explained during a meeting with the Employer submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.

Broker Signature	Date

General Agent Override Information

General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip

Admin Kit

Send Admin Kit To:	Address

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
Filing Company:	*Pan-American Life Insurance Company*	*State Tracking Number:*	*41899*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*Middle Med Filing*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
Filing Company:	*Pan-American Life Insurance Company*	*State Tracking Number:*	*41899*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*Middle Med Filing*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice — Approved-Closed — 01/29/2009

Comments:

Attachments:

Arkansas Certificate of Compliance.pdf

Arkansas Readability.pdf

Review Status:

Bypassed -Name: Application — Approved-Closed — 01/29/2009

Bypass Reason: Application is filed in the Form Schedule Tab.

Comments:

Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: Pan-American Life Insurance Company

Form Number (s):

PAL-2008-P-AR
PAL-2008-C-AR
PAL-2008-APP-AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Jennifer Lafleur

Digitally signed by Jennifer Lafleur
DN: cn=Jennifer Lafleur, o=Pan-American, ou=Worksite, email=jjlafleur@panamericanlife.com, c=US
Date: 2009.01.21 12:33:57 -06'00'

Signature of Company Officer

PAN-AMERICAN LIFE INSURANCE COMPANY

READABILITY CERTIFICATION

This is to certify that the form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

Form Number and Name		**Score**
PAL-2008-P-AR, et al	Master Policy	54

Jennifer Lafleur

Digitally signed by Jennifer Lafleur
DN: cn=Jennifer Lafleur, o=Pan-American, ou=Worksite, email=jjlafleur@panamericanlife.com, c=US
Date: 2009.01.21 12:32:50 -06'00'

Jennifer Lafleur

SERFF Tracking Number:	*PNLG-125817483*	*State:*	*Arkansas*
Filing Company:	*Pan-American Life Insurance Company*	*State Tracking Number:*	*41899*
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Product Name:	*Middle Med Filing*		
Project Name/Number:	*/*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Master Group Policy	11/19/2008	Arkansas Policy Filing Version.pdf
No original date	Form	Certificate of Coverage	11/19/2008	Arkansas Certificate Filing version.pdf

PAN-AMERICAN LIFE INSURANCE COMPANY

PAN-AMERICAN LIFE CENTER
601 Poydras Street
New Orleans, Louisiana
TOLL FREE: [1-xxx-xxx-xxxx]

HOSPITAL/SURGICAL MEDICAL EXPENSE PLAN

POLICYHOLDER PLAN NUMBER:
POLICYHOLDER:
EFFECTIVE DATE:
PLAN ANNIVERSARY DATE:
PREMIUMS PAYABLE: [Monthly]
STATE: Arkansas

Pan-American Life Insurance Company agrees to pay the benefits provided in the Plan in accordance with the provisions of this Plan for each Employee of the Policyholder who is due benefits under the terms and conditions of the Plan.

This Plan is issued in consideration of the Policyholder's Application and the payment of premiums shown herein. A copy of the application is attached to and is a part of this Plan.

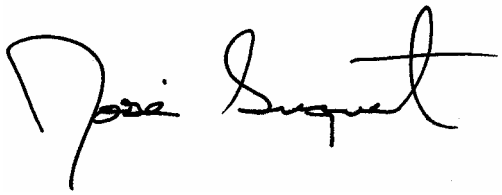
This Plan will take effect at 12:01 AM on the Date shown above. The Plan Anniversary will be the Plan Anniversary Date shown above and on the same date in each subsequent year.

The first premium is due and payable on the Effective Date. Each subsequent premium is due and payable as shown above.

This Plan, the Application, and the Employees' Enrollment Form form the entire contract between the parties.

This Plan is delivered in and is subject to the laws of the state shown above.

PAN-AMERICAN LIFE INSURANCE COMPANY



Chairman of the Board
President and Chief Executive Officer

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SECTION I: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

WHO IS AN ELIGIBLE EMPLOYEE?

Employees working at least an average of [30, 35 hours per week] will be eligible for coverage on the first day of the month following [30, 60, 90] days of employment.

WHO IS ELIGIBLE TO ENROLL AS A COVERED PERSON?

An Employee of the Policyholder.

WHO IS ELIGIBLE TO ENROLL AS A DEPENDENT?

1. Be the legal spouse of the Member; or

2. Be the natural child, step-child, or adopted child of the Member; or the child for whom the Member is the legal guardian, or the child who is the subject of a lawsuit for adoption by the Member, if the Member has the legal responsibility for the health of the child, or the child supported pursuant to a court order imposed on the Member (including a qualified medical child support order) or a grandchild of the Member who is also a Dependent of the Member for federal income tax purposes, provided that child:
    a. Is unmarried and legally dependent upon the Member for support;
    b. Has not reached age nineteen (19);
    c. Is age nineteen (19) but less than age twenty-five (25) and is a full-time student; or
    d. Is age nineteen (19) or older and is incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) years of age. You must submit proof of the child's condition and dependence to Us after the date the child ceases to qualify as a Dependent under section (b) above.

    A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

A. Enrollment during an Open Enrollment Period

If the Employee or Dependent eligibility criteria are met, the Employee may enroll during the Open Enrollment Period by submitting a completed Enrollment Form, together with any applicable premium.

If enrolled during the Open Enrollment Period, the effective date of coverage will be the Plan Anniversary Date.

B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, You become eligible for coverage as a Member or a Dependent, You may enroll as a Member within thirty-one (31) days of the day on which You met the eligibility criteria. To enroll, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, Your effective date of coverage will be the day on which You meet the eligibility criteria.

2. If You are a Member who is enrolled for Employee coverage only, You may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. Newborn children of the Member are covered for the first thirty-one (31) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.

3. If You are a Member who is enrolled for Employee and family coverage, You may enroll a newborn child prior to the birth of the child or within ninety (90) days after the child's birth. Newborn children of the Member are covered for the first ninety (90) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.

4. If You are a Member who is enrolled for Employee coverage only, You may enroll an adopted child or child for whom You have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with You for adoption or within thirty-one (31) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

5. If You are a Member who is enrolled for Employee and family coverage, You may enroll an adopted child or child for whom You have been granted legal guardianship within sixty (60) days of the date the child is legally placed with You for adoption or within sixty (60) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

C. Special Open Enrollment Period

An eligible person and/or Dependent may also be able to enroll during a special Open Enrollment Period. A special Open Enrollment Period is not available to an eligible person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An eligible person and/or Dependent do not need to elect Cobra continuation coverage to preserve special enrollment rights. Special enrollments are available to an eligible person and/or Dependent even if Cobra is elected.

A special Open Enrollment Period applies to an eligible person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Acquiring a child as a result of being a party in a suit in which the adoption of the child by the Covered Person is sought.
- Placement for adoption.
- Marriage.

A special Open Enrollment Period applies for an eligible person and/or Dependent who did not enroll during the initial Open Enrollment Period or any applicable Open Enrollment Period if the following are true:

- The eligible person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the initial Open Enrollment Period or any applicable Open Enrollment Period; and

- Coverage under the prior plan ended because of any of the following:

  - Loss of eligibility (including, without limitation, legal separation, divorce or death).

  - The Policyholder stopped paying the contributions. This is true even if the eligible person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the Policyholder.

  - In the case of Cobra continuation coverage, the coverage ended.

  - The eligible person and/or Dependent no longer lives or works in a service area if no other benefit option is available.

  - The plan no longer offers benefits to a class of individuals that include the eligible person and/or Dependent.

  - An eligible person and/or Dependent incur a claim that would exceed a lifetime limit on all benefits.

D. Completion of Enrollment Form

Each Employee will need to complete the Enrollment Form. False, incomplete or intentional misrepresentation of a material fact provided in any Enrollment Form may cause the coverage of the Employee and/or his Dependent(s) to be null and void from its inception. A statement will not be used in a contest to void, cancel or non-renew the coverage or to reduce benefits unless:

1. the statement is in a copy of the Enrollment Form; and
2. a signed copy of the Enrollment Form is or has been furnished to the Employee or his/her representative.

Coverage will only be contested because of fraud or intentional misrepresentation of a material fact on an Enrollment Form.

E. Hospitalization on the Effective Date of Coverage

If the Employee is confined in a Hospital on the effective date of coverage; We must be notified of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter.

[F. Late Enrollee

A "Late Enrollee" is a person (including Yourself) for whom You do not elect coverage within 31 days of the date the person becomes eligible for such coverage.

An eligible Employee or Dependent will be required to provide proof of good health, at his cost, if he applies for coverage more than thirty-one (31) days after he becomes eligible or if he applies for reinstatement of coverage that was cancelled at his request.

Exceptions:

- A person will not be considered to be a Late Enrollee if all of the following are met:

  You did not elect coverage for the person involved within 31 days of the date You were first eligible (or during an open enrollment) because at that time the person was covered under other creditable coverage; and

- the person loses such coverage because:
  a. of termination of employment in a class eligible for such coverage;
  b. of reduction in hours of employment;
  c. Your spouse dies;
  d. You and Your spouse divorce or are legally separated;
  e. such coverage was COBRA continuation and such continuation was exhausted; or
  f. the other plan terminates due to the employer's failure to pay the premium or for any other reason; and

- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

If You are not considered a Late Enrollee, coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if You did not elect, when the person was first eligible, coverage for:

- A child who meets the definition of a Dependent, but You elect it later in compliance with a court order requiring You to provide such coverage for Your Dependent child. Such coverage will become effective on the date specified by the Policyholder. Any limitation as to a preexisting condition may apply.

- A spouse, but You elect it later and within 31 days of a court order requiring You to provide such coverage for Your Dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.

- Yourself and You subsequently acquire a Dependent, through marriage, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

- Yourself and You subsequently acquire a Dependent, through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

- Yourself and Your spouse and You subsequently acquire a Dependent through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself, Your spouse, and any such Dependent within 90 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

G. Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of Dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date Your coverage becomes effective; and
- You make written request for coverage for the child within 31 days (60 days if You already have Dependents covered) of the date the child is placed with You for adoption.

Coverage for the child will become effective on the date the child is placed with You for adoption. If request is not made within such 31 days (60 days if You already have Dependents covered), coverage for the child will be subject to all of the terms of this Plan.

H. Special Rules Which Apply to a Child Who Must Be Covered Due to a Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom You are required to provide health coverage as the result of a qualified medical child support order issued on or after the date Your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by the Policyholder.

If You are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

SECTION 2: DEFINITIONS

Throughout this Plan, you will find many terms in capital letters. These terms have special meaning in the Plan. When you find a term which has been capitalized, its meaning may be found in this section.

ACCIDENT
An unforeseen, unexpected and involuntary event which causes the Covered Person to suffer an Injury while covered under the Plan.

ACCIDENTAL BODILY INJURY/INJURY
Physical pain or impairment of a physical condition to a Covered Person that is:

A. Unforeseen;
B. Unexpected;
C. Involuntary; and
D. Due to violent and external means.

ALTERNATE FACILITY
A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services;
- Emergency Health Services;
- Urgent Care services;
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

APPLICATION
The form completed by the Policyholder in applying for coverage under the Policy.

CALENDAR YEAR
The period from January 1 through December 31 of the same year.

COMPLICATIONS OF PREGNANCY
Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible

Complications of pregnancy does not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy

CONVALESCENT FACILITY
An institution (or distinct part thereof) which meets fully every one of the following tests:

1. it is licensed to provide, and is engaged in providing on an inpatient basis, for persons convalescing from an injury or illness:
   - professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.), under the direction of a registered graduate nurse (R.N.);
   - Physician restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. its services are provided for compensation from its patients and under the fulltime supervision of a Physician or registered graduate nurse (R.N.);
3. it provides 24 hour per day nursing services by licensed nurses under the direction of a fulltime registered graduate nurse (R.N.);
4. it maintains a complete medical record on each patient;
5. it has an effective utilization review plan; and
6. it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders.

COVERED PERSON
A person who is eligible for coverage as an Employee or as a Dependent for whom premium is paid. A person who is eligible for coverage as an Employee or a Dependent according to the class(es) shown in the Policyholder's Application. No person may be covered as both an Employee and a Dependent at the same time. If Dependent coverage is elected, only one (1) person in the family may be covered as the Employee.

COVERED SERVICE(S)
Those health services provided for the purpose of preventing, diagnosing or treating a Sickness or Injury. A Covered Service is a health care service or supply described in "Section 3: Covered Services" as a Covered Service, which is not excluded under "Section 5: Exclusions".

CREDITABLE COVERAGE
Health care coverage under any of the types of plans listed below.

- a self-funded or self-insured Employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 et seq.);
- a group health benefit plan provided by a health insurance carrier or a health maintenance organization;
- an individual health insurance policy or evidence of coverage;
- Part A or Part B of Title XVIII of the Social Security Act (42 USC Section 1395c et seq.);
- Title XIX of the Social Security Act (42 USC Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 USC Section 1396s);
- Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.);
- a medical care program of the Indian Health Service or of a tribal organization;
- a state or political subdivision health benefits risk pool;
- a health plan offered under Chapter 89 of Title 5, United States Code (5 USC Section 8901 et seq.);
- a public health plan;
- a health benefit plan under Section 5(e) of the Peace Corps Act (22 USC Section 2504(e)); and
- short-term limited duration insurance;
- CHIP Program.

Creditable Coverage does not include:

- accident-only, disability income insurance, or a combination of accident-only and disability income insurance;
- coverage issued as a supplement to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit only insurance;
- coverage for onsite medical clinics;
- other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations;
- if offered separately, coverage that provides limited scope dental or vision benefits;
- if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits;
- if offered separately, coverage for other limited benefits specified by federal regulations;
- if offered as independent, noncoordinated benefits, coverage for specified disease or illness;
- if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; or
- Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 USC Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

DEDUCTIBLE/DEDUCTIBLE AMOUNT

The amount of money the Covered Person must pay for Eligible Expenses during each Calendar Year before the Plan begins to pay benefits.

DEPENDENT

A person who is:

1. The Employee's spouse;
2. Each unmarried child from birth to age 19 who is primarily dependent upon the Employee for support and maintenance;
3. Each unmarried child at least 19 years of age to age 25 who is primarily dependent upon the Employee for support and maintenance and who is a full-time student. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months; or
4. Each unmarried child at least 19 years of age:
   a) who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental or physical handicap;
   b) who was so incapacitated and is a Covered Person under this Policy on his or her 19th birthday; and
   c) who has been continuously so incapacitated since his or her 19th birthday.

If the dependent child is a full-time student and is a member of:

- the National Guard or any reserve component of the armed forces of the United States who are called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or
- the National Guard ordered to active State duty, including duty under 35 Pa.C.S. Ch. 76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days;

and is called to military duty, coverage under this Plan will not terminate if the dependent child reaches age 23 while on military duty, or after returning home, subject to the extension qualification requirements listed below.

Coverage under this Plan shall be extended for a period equal to the duration of the dependent's service on active duty or active State duty, or until the dependent is no longer a full-time student. In order to qualify for an extension, the dependent must:

1. Submit a form approved by the Department of Military and Veterans Affairs notifying Pan-American Life Insurance Company that the dependent has been placed on active duty.
2. Submit a form approved by the Department of Military and Veterans Affairs notifying Pan-American Life Insurance Company that the dependent is no longer on active duty.
3. Submit a form approved by the Department of Military and Veterans Affairs showing that the dependent has re-enrolled as a full-time student for the first term or semester starting 60 or more days after their release from active duty.

As used above, the term "full-time student" means a student enrolled in an approved institution of higher education pursuing an approved program of education equal to or greater than 12 credit hours or its equivalent.

Children include:

- The Member's biological children.
- The Member's adopted children.
- The Member's stepchildren.
- Any other child the Member supports who has a parent-child relationship with the Member.

If the Member has had the "Declaration of Domestic Partnership" completed and signed and the Declaration is acceptable to the Policyholder, the Member may also cover a person:

1. who is Your same sex "domestic partner"; and
2. who is named as such in Your Declaration.

No person may be covered both as an Employee and Dependent and no person may be covered as a Dependent of more than one Employee.

DOCTOR/PHYSICIAN

A person who is:

A. Licensed and recognized as a Provider of medical services by the State in which he practices; and
B. Recognized as a Provider of medical services by the insurance law of the State in which the Covered Person resides; and
C. Acts within the scope of his license; and
D. Gives treatment for which benefits are payable under the Plan, and
E. Other than for dental care covered under the Policy, Not one of the following:
    1. A person who ordinarily resides in the Covered Person's household; or
    2. A member of the Covered Person's immediate family.

DOMESTIC PARTNER

A person who is mentally competent to contract and either at least 18 years old, the age of majority or legally emancipated. In order to be eligible for Dependent coverage as a Domestic Partner, the person must not be sharing a permanent resident with another person who has obtained the age of majority, and must have the competency to consent to a contract for permanent residence. Evidence that the Domestic Partner and the Employee have shared a common residence and financial assets and obligations for an extended period of time must be provided to Us.

EFFECTIVE DATE

The date coverage under the Plan goes into effect for a Policyholder and his eligible Employees. It is shown in the Summary of Benefits of the Policyholder's Plan. An Employee's Effective Date of coverage is determined by the eligibility rules of the Plan and the payment of premium.

ELIGIBLE EXPENSE
Care, treatment, services, and supplies which must be:

1. Listed as an eligible Covered Service in the Plan; or authorized by the Utilization Management Company and approved by the Plan as an alternative form of treatment or facility; and
2. Medically Necessary for the care or treatment of an Injury or Illness; and
3. Recommended and approved by a Doctor.

An expense will not be an Eligible Expense to the extent that:
1. It is in excess of the Maximum Allowable Charge; or
2. The fee or charge would not have been made in the absence of medical coverage except for Medicaid and Tax Supported Institutions.

Expenses must be incurred after the person becomes covered under the Plan. We will determine the Eligible Expenses of the Plan. Charges in excess of the Maximum Allowable Charge will not be considered as Eligible Expenses.

EMERGENCY CARE.
Health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
1. placing the person's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of a bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMPLOYEE
An Employee of the Policyholder named in the Summary of Benefits, who qualifies for coverage according to an eligible class as described in the Application.

No person may be covered as both an Employee and a Dependent at the same time. If Dependent coverage is elected, only one (1) person in the family may be covered as an Employee.

ENROLLMENT FORM
The document completed by the Employee in electing coverage under the Policyholder's Plan.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES
Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If the insured has a life-threatening Illness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Service for that Illness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those identified by the National Institutes of Health.

HOME HEALTH CARE AGENCY

This is an agency that:

1. mainly provides skilled nursing and other therapeutic services; and
2. is associated with a professional group which makes policy; this group must have at least one physician and one R.N.; and
3. has full-time supervision by a physician or a R.N.; and
4. keeps complete medical records on each person; and
5. has a full-time administrator; and
6. meets licensing standards.

HOME HEALTH CARE PLAN

This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

1. prescribed in writing and reviewed at least every two month by the attending Physician; and
2. certified by the attending Physician as necessary for medical purposes and that the care and treatment is an alternative to confinement in a Hospital or Convalescent Facility.

HOSPICE CARE

Care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

HOSPICE CARE AGENCY

This is an agency or organization which has Hospice Care available 24 hours a day. It meets any licensing or certification standards set forth by the jurisdiction where it is, and provides:

1. skilled nursing services; and
2. medical social services; and
3. psychological and dietary counseling; and
4. bereavement counseling for the immediate family.

HOSPICE CARE PROGRAM

This is a written plan of Hospice Care, which is established by and reviewed from time to time by a Physician attending the person and appropriate personnel of a Hospice Care Agency. It is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families. This includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

HOSPICE FACILITY

This is a facility, or distinct part of one, which:

1. Mainly provides inpatient Hospice Care to terminally ill persons.
2. Charges its patients.
3. Meets any licensing or certification standards set forth by the jurisdiction where it is located.
4. Keeps a medical record on each patient.
5. Provides an ongoing quality assurance program; this includes reviews by Physicians other than those who own or direct the facility.
6. Is run by a staff of Physicians; at least one such Physician must be on call at all times.
7. Provides, 24 hours a day, nursing services under the direction of a R.N.
8. Has a full-time administrator.

HOSPITAL

An institution, operated as required by law, which is all of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

ILLNESS/SICKNESS
A. A disorder or disease of the mind or body; or
B. A pregnancy.

INDIVIDUAL/INDIVIDUALIZED TREATMENT PLAN
A treatment plan with specific attainable goals and objectives that are appropriate to:
A. the patient; and
B. the program's treatment modality.

INITIAL ENROLLMENT PERIOD
The initial period of time, as we agree with the Policyholder, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

INPATIENT REHABILITATION FACILITY
A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

MAXIMUM ALLOWABLE CHARGE
The amount determined by Us to be the appropriate fee. For services rendered by a Participating Provider, an amount not to exceed the Maximum Allowable Fee.

For all other charges, an amount not exceeding a charge routinely made by Providers in the locality where the charge is incurred for similar services or supplies. Consideration will be given to:
1. The Covered Person's condition; and
2. Unusual circumstances or complications; and
3. Requirements for additional time, skill or experience.

We will determine the Maximum Allowable Charge and if it is covered by the Plan.

MAXIMUM ALLOWABLE FEE
The amount agreed upon between a Participating Provider and the Plan (after any applicable Deductible) for Eligible Expenses for care, services, supplies and treatment or other medical care. If the Utilization Management Company negotiates an amount on a pre- or post-treatment basis for non-contracted Provider services, the charges will be the negotiated amount.

MEDICALLY NECESSARY
Any services or supplies provided for the diagnosis and treatment of a specific Illness, Injury, or condition which are:
A. Ordered or recommended by a Doctor; and
B. Required for the treatment or management of a medical condition or symptom; and
C. The most appropriate supply or level of service which can safely be provided to the Covered Person; and
D. Provided in accordance with approved and generally accepted medical or surgical practice; and
E. Not for the convenience of the Covered Person, his Doctor, or another Provider; and
F. Not for services or supplies which are experimental or investigational; and
G. Furnished in the least intensive type of medical care setting required by the Covered Person's condition.

Services and supplies will not automatically be considered Medically Necessary because they were ordered by a Doctor.

MENTAL ILLNESS
Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.

NETWORK
Care, services, supplies and treatment which are obtained through a Participating Provider.

NON-NETWORK
Care, services, supplies and treatment which are obtained through a Non-Participating Provider.

OPEN ENROLLMENT PERIOD
A period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. We and the Policyholder will agree upon the period of time that is the Open Enrollment Period.

OUTPATIENT REHABILITATION FACILITY
A facility (or a special unit of a Hospital) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an outpatient basis, as authorized by law.

PARTICIPATING PROVIDER
A participating Hospital, a Primary Care Physician (PCP), a specialist Physician, and any other licensed health care services Provider who has contracted with the Us to provide health care services to Covered Persons as Network benefits.

PARTICIPATING PROVIDER ORGANIZATION/PPO
An organization which establishes an arrangement between payers (Policyholders or insurers) and health care Providers. The Providers selected for participation in the PPO agree to be reimbursed at negotiated fees for their services.

PLAN
The benefit plan elected by the Policyholder which covers its Employees.

POLICYHOLDER
The [employer or plan sponsor] named in the Summary of Benefits as the Policyholder.

PRIMARY CARE DOCTOR/PHYSICIAN
A Physician who specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

PROVIDER
Any person or health care facility duly licensed or legally authorized to render care or services covered under the Plan.

REIMBURSEMENT PERCENTAGE
The percent of Eligible Expenses payable under the Plan and shown in the Summary of Benefits.

SKILLED NURSING FACILITY
A Hospital or nursing facility that is licensed and operated as required by law.

SPECIALIST CARE DOCTOR/PHYSICIAN
A Physician who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

TOTAL DISABILITY/TOTALLY DISABLED
With respect to primary insured covered under this Plan, the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability and with respect to any other individual person insured under this Plan, confinement as a bed patient in a Hospital.

URGENT CARE CLINIC
A facility, other than a Hospital, that provides Covered Services that are required to prevent serious deterioration of Your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

UTILIZATION MANAGEMENT COMPANY/UMC
A company or organization chosen by Us which meets the standards for utilization review established by the American Managed Care and Review Association and is certified or licensed to do business in the state as a utilization review agency, if applicable.

WAITING PERIOD
The time period an Employee must be employed by the Policyholder before becoming eligible for coverage under the Policy.

WE/US/OUR/COMPANY
Refers to Pan-American Life Insurance Company.

YOU/YOUR
The Employee who is covered under the Policyholder's Plan.

SECTION 3
SUMMARY OF BENEFITS/COVERED SERVICES

Calendar Year Deductible
Network: [$250, $500, $1,000, $2,000]
Non-Network: [$500, $1,000, $2,000, $4,000]
[2 Times, 2.5 Times, 3 Times, None] Calendar Year Family Deductible Limit

Overall Maximum per Calendar Year [(does not include Inpatient Facility Expenses)]
Inpatient & Outpatient: [$10,000, $25,000, $50,000, $75,000, $100,000] (combined for Network and Non-Network Coverage)
Outpatient Limited to: [$2,500, $5,000, $7,500, $10,000] (combined for Network and Non-Network Coverage)

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Hospital Inpatient Facility Expenses. This benefit pays for charges after the deductible for a total of 30 days each Calendar Year up to the following: [$2,000 per day for the first 4 days of Hospital confinement; and $1,000 per day for days 5 through 30]; [$250, $500, $1,000, $1,000, $2,000, $2,500, $3,000 per day].	$0	Yes	[100%, 85%, 80%, 75%]	[100%, 65%, 60%, 55%]
Physician Inpatient Services.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Outpatient Surgery, Diagnostic, and Therapeutic Services.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Primary Care Doctor's Office Visits (Non-Surgical).	[$15, $20, $25, $30] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Specialist Care Doctor's Office Visits (Non-Surgical).	[$30, $35, $40] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Urgent Care Clinic Visits (Non-Surgical).	[$35, $50] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Injections Received In A Doctor's Office. Benefits are available for injections received in a Doctor's office when no other health service is received.	[$15, $20, $25, $30] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Maternity Services. Benefits for Pregnancy will be paid at the same level as Covered Services for any other condition, Illness, or Injury. This includes all maternity related services for prenatal care, postnatal care, delivery, and any related complications. We will pay Covered Services for an Inpatient say of at least: 48 hours for the mother and newborn child following a normal vaginal delivery; 96 hours for the mother and newborn child following a cesarean section delivery.				
In Vitro Fertilization. Benefits for In Vitro Fertilization will be paid at the same level as Covered Services for any other condition, Illness, or Injury. Any pre-existing condition limitation shall not exceed a period of twelve (12) months. Lifetime maximum for In Vitro Fertilization: $15,000				
Hospice Care Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Home Health Care Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Spinal Disorder Treatment Expenses. Calendar Year maximum of 2 visits.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Routine Preventive Care*. This benefit has a combined (Network or Non-Network) Calendar Year maximum of [$150, $250, $500].	[$10, $15, $20, $25, $30] [Network Only] per visit.	No (Network); [Yes] [No] (Non-Network)	100%	[85%,80%, 75%, 65%, 60%, 55%]
*Mammograms: Benefits paid for these conditions are over and above the benefits paid for any other illness or condition. We will pay not less than fifty dollars ($50.00) for each screening mammogram, which shall include payment for both the professional and technical components.				
Private Duty Nursing Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Prosthetic Devices Expenses. Calendar Year Maximum of $500.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Rehabilitation Services-Outpatient Therapy Calendar Year Maximum of $1,000.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Durable Medical Equipment Expenses. Calendar Year Maximum of $500.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Ambulance Services Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Emergency Care Services. Services that are required to stabilize or initiate treatment in an Emergency. Emergency Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. [For Emergency Room Visits as the result of a Sickness, there is a [$250, $500, $1,000, None] (combined for Network or Non-Network Coverage) Calendar Year Maximum.]	$0	Yes	[85%, 80%, 75%] after the Deductible	

ADDITIONAL BENEFITS				
COVERED SERVICE	**CO-PAY AMOUNT**	**NEED TO MEET CALENDAR YEAR DEDUCTIBLE?**	**NETWORK COVERAGE**	**NON-NETWORK COVERAGE**
Reconstructive Surgery After Mastectomy Benefits will be payable on the same basis as any other similarly covered Inpatient Hospital Expense or Medical—Surgical Expense, as shown on the Summary of Benefits.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
OTHER BENEFITS				
Other Medical Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]

Pregnancy Coverage: Benefits are payable for pregnancy-related expenses of female Employees and dependents, including Complications of Pregnancy, on the same basis as any other illness.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following an uncomplicated vaginal delivery; and a minimum of 96 hours following an uncomplicated cesarean delivery. If, after consultation with the attending Physician, a person is discharged earlier, benefits will be payable in accordance with recognized medical standards for that care by a health care provider, a registered nurse or another other appropriate licensed health care provider. The post delivery care may be provided at the women's home (at her option), a health care provider's office, a health care facility or another appropriate location. Charges for such post-delivery home visits will be paid at 100% and will not be subject to any Calendar Year Deductible.
- Authorization of the first 48 hours of such confinement following an uncomplicated vaginal delivery or the first 96 hours of such confinement following an uncomplicated cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. The Employee, his/her Physician, or other health care provider may obtain such authorization by calling the number shown on the Employee's ID Card.

Pregnancy-related expenses are not subject to any Preexisting Condition limitation.

PREEXISTING CONDITION PROVISION

A "preexisting condition" is an injury or disease for which a person:
received treatment or services; or
took prescribed drugs or medicines;

during the[90] days immediately preceding the person's effective date of coverage (or, if the Plan requires You to serve a probationary period, the [90] days immediately preceding the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Policy and Certificate, whichever applies, to determine a person's effective date of coverage.

For the first [365] days following such date, Covered Services do not include any expenses for treatment of a preexisting condition.

[With respect to a Late Enrollee, a preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment. For the first 18 months after a Late Enrollee's enrollment date, Covered Services do not include any expenses for treatment of a preexisting condition.]

Special Rules As To A Preexisting Condition:

If a person had creditable coverage, then the preexisting limitation period under this Plan will be reduced by the number of days of prior creditable coverage.

As used above: "continuous creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Members' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED

We will not treat genetic information as a preexisting condition in the absence of a diagnosis of the condition related to the information.

LIMITATIONS:

Not covered are charges for a service or supply furnished by a Participating Provider that exceeds the negotiated charge agreed to by Participating Providers.

Explanation of Some Important Plan Provisions

Network and Non-Network Coverage Year Deductible
This is the amount of Network and Non-Network care, and other health care Covered Services the Employee pays each Calendar Year before benefits are paid.
Network and Non-Network Care Family Coverage Year Deductible Limit
This limit applies to all Covered Services incurred for Network, Non-Network Care, and other health care by the Employee or his/her covered dependents. After that limit is reached, the Employee and his/her covered dependents will be deemed to have met separate Network and Non-Network coverage year Deductibles. The Network and Non-Network Family Coverage Year Deductible Limit is shown in the Summary of Benefits.

COVERED SERVICES

1. HOSPITAL INPATIENT FACILITY EXPENSES

Benefits are available for supplies, room and board, and non-Physician services received during the inpatient stay. Included are charges for services (non-Physician) made in connection with room occupancy. Benefits for Physician services are described under the section titled Physician Inpatient Services.

2. PHYSICIAN INPATIENT SERVICES (SURGICAL AND NON-SURGICAL)

Covered Services include the following charges made by a Physician:

Inpatient surgical and non-surgical services as follows:

1. Surgical services are the services of the operating Physician in performing a surgical procedure. This includes: The usual and related preoperative care; the administering of an anesthetic; the usual and related postoperative care.
2. Surgical assistance services are the services of a Physician in giving needed technical assistance to the operating Physician during a surgical service for which a benefit is paid under this Plan. No benefit is paid if such assistance is routinely done as a service by an intern; a resident Physician; or a house officer of a Hospital.
3. Anesthesia services are the services of a Physician in administering an anesthetic when a surgical services benefit is paid under this Plan. No benefit is paid if the anesthetic is administered by the operating Physician or his or her assistant.
4. Non-surgical medical treatment given to a Covered Person while confined as an inpatient in a Hospital, treatment facility, Inpatient Rehabilitation Facility, Convalescent Facility, Skilled Nursing Facility, or Hospice Facility and for consultation services given to a Covered Person while confined as an inpatient in such facility. Consultation services must be asked for by the attending Physician. A "consultation" is an exam of the Covered Person, a review of his or her x-ray and lab exams, and a review of the Covered Person's medical history. It will include a written report by the consulting Physician if the attending Physician requests one.

   No benefits are paid for consultation services:
   a. If the consulting Physician performs surgery as a result of the consultation.
   b. For staff consultations required by a facility.

3. OUTPATIENT SURGERY, DIAGNOSTIC/THERAPEUTIC AND THERAPEUTIC SERVICES

A. OUTPATIENT SURGICAL SERVICES

This benefit pays for Covered Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Surgeries performed in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

B. OUTPATIENT DIAGNOSTIC SERVICES

When ordered by a Physician, this benefit pays for Covered Services received on an outpatient basis at a Hospital or Alternate Facility for lab and radiology/x-ray, mammograms, bone mass measurement services, pap test, prostate cancer examination and testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, benefits are described under the Doctor's Office Visits Services below. It does not include CT Scans, PET Scans, MRI's, or nuclear medicine.

C. OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES-CT SCANS, PET SCANS, MRI AND NUCLEAR MEDICINE

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Diagnostic Services performed for CT Scans, PET Scans, MRI's, and Nuclear Medicine in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

D. OUTPATIENT THERAPEUTIC TREATMENTS

This benefit includes Covered Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge required for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Doctor's Office, benefits are described under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

4. PRIMARY CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)

We will pay for Covered Services received in a Primary Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Primary Care Doctor specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

5. SPECIALIST CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)

We will pay for Covered Services received in a Specialist Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Specialist Care Doctor is a Doctor who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

6. URGENT CARE CLINIC VISITS (NON-SURGICAL)

We will pay for Covered Services received in an Urgent Care Clinic for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Urgent Care Clinic Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

An Urgent Care Clinic provides services at a facility, other than a Hospital, and provides Covered Services that are required to prevent serious deterioration of the Covered Person's health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

7. INJECTIONS RECEIVED IN A DOCTOR'S OFFICE

Benefits are paid under this benefit for injections received in a Physician's office when no other health service is received.

Childhood immunizations are paid under the Routine Preventive Care Expenses benefit.

8. MATERNITY SERVICES

Benefits for Pregnancy will be paid at the same level as Covered Services for any other condition, Illness, or Injury. This includes all maternity related services for prenatal care, postnatal care, delivery, and any related complications. We will pay Covered Services for an Inpatient say of at least: 48 hours for the mother and newborn child following a normal vaginal delivery; 96 hours for the mother and newborn child following a cesarean section delivery.

9. HOSPICE CARE EXPENSES

Charges made for the following furnished to a person for Hospice Care when given as a part of a Hospice Care Program are included as Covered Services.

Facility Expenses
The charges made in its own behalf by a:

1. Hospice Facility;
2. Hospital;
3. Convalescent Facility;

which are for:
Board and room and other services and supplies furnished to a person while a full-time inpatient for:

1. pain control; and
2. other acute and chronic symptom management.

Not included is services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses

- Charges made by a Hospice Care Agency for:
  1. Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day.
  2. Medical social services under the direction of a Physician. These include assessment of the person's:
     i. social, emotional, and medical needs; and
     ii. the home and family situation;
     iii. identification of the community resources which are available to the person; and
     iv. assisting the person to obtain those resources needed to meet the person's assessed needs.
  3. Psychological and dietary counseling.
  4. Consultation or case management services by a Physician.
  5. Physical and occupational therapy.
  6. Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
  7. Medical supplies.
  8. Drugs and medicines prescribed by a Physician.
- Charges made by the providers below, but only if the provider is not an Employee of a Hospice Care Agency; and such agency retains responsibility for the care of the person.
  1. A Physician for consultant or case management services.
  2. A physical or occupational therapist.
- Not included are charges made:
  1. For bereavement counseling.
  2. For funeral arrangements.
  3. For pastoral counseling.
  4. For financial or legal counseling. This includes estate planning and the drafting of a will.
  5. For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
  6. For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

10. HOME HEALTH CARE EXPENSES

Home health care expenses are Covered Services if:
1. the charge is made by a Home Health Care Agency; and
2. the care is given under a Home Health Care Plan; and
3. the care is given to a Covered Person in his or her home; and
4. the Covered Person is homebound.

Home health care expenses include charges for:
1. Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
2. Part-time or intermittent home health aide services for patient care when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
3. Physical, occupational, and speech therapy.
4. Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.

The following to the extent they would have been covered under this Plan if the Covered Person had been Hospital confined:
1. medical supplies;
2. drugs and medicines prescribed by a physician; and
3. lab services provided by or for a home health care agency.

Home health care expenses do not include charges incurred for:

1. Services or supplies that are not a part of the Home Health Care Plan.
2. Services of a person who usually lives with a Covered Person or who is a member of the Covered Person's spouse's family.
3. Services of a social worker.
4. Transportation.
5. Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
6. Services that are custodial care. However, if the Covered Person is a minor or an adult who is dependent upon others for custodial care, coverage will be provided during times when there is a family member or caregiver present in the home to meet the Covered Person's custodial care needs. Coverage for home health care expenses is not determined by the availability of providers to provide care or services. The absence of a provider to perform a custodial care service does not cause the service to become a covered medical expense.

11. SPINAL DISORDER TREATMENT BENEFIT

Covered Services include charges incurred for:

1. manipulative (adjustive) treatment; or
2. other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Maximum Visits per Coverage Year will be payable for all expenses incurred in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full time inpatient in a Hospital
- for treatment of scoliosis
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating Physician.

12. ROUTINE PREVENTIVE CARE EXPENSES

Covered Services include charges made by a Physician for preventive care exams performed on a Covered Person for a reason other than to diagnose or treat a suspected or identified injury or disease.

Included as a part of the exam are:

1. X-rays, lab, and other tests given in connection with the exam; and
2. materials for the administration of immunizations for infectious disease and testing for tuberculosis.

Covered expenses for routine preventive care provided under this benefit include, but are not limited to, those charges made for:

1. Physical exams.
2. Cytological screening.
3. Colon cancer examinations and laboratory tests for:
   a. Covered persons who are fifty (50) years of age or older;
   b. Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
   c. Covered persons experiencing the following symptoms of colorectal cancer as determined by a licensed physician:
   (1) Bleeding from the rectum or blood in the stool; or
   (2) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days;
4. Prostate specific antigen tests and digital rectal exams.
5. Bone mass density measurements.
6. Mammograms
   a. A baseline mammogram for a woman covered by such a policy who is thirty-five (35) to forty (40) years of age;
   b. A mammogram for a woman covered by such a policy who is forty (40) to forty-nine (49) years of age, inclusive, every one (1) to two (2) years based on the recommendation of the woman's physician;
   c. A mammogram each year for a woman covered by such a policy who is at least fifty (50) years of age;
   d. Upon recommendation of a woman's physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer; and
   e. Insurance coverage for screening mammograms will not prejudice coverage for diagnostic mammograms as recommended by the woman's physician.

   We will not pay for mammography's performed in an unaccredited facility.
7. Routine Pap Smears
   Covered Services include charges incurred for:
   a. one routine gynecological exam each Calendar Year; and
   b. an annual routine Pap smear.

Mammography means radiography of the breast.

Screening mammography is a radiological procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two (2) views of each breast and includes a physician's interpretation of the results of the procedure.

Not included under this benefit are any exams; or other preventive services and supplies; which are specifically covered elsewhere in this Plan. The most that will be paid for all covered routine preventive care expenses incurred by a Covered Person in a Calendar Year under this benefit is the Routine Preventive Care Maximum.

13. PRIVATE DUTY NURSING EXPENSES

The charges of a:

1. R.N;
2. L.P.N.; or
3. nursing agency;

for private duty nursing provided on an inpatient or outpatient basis are deemed Covered Services.

No other charges made by an R.N. or L.P.N. or a nursing agency for private duty nursing are covered.

Not included as private duty nursing is:

1. that part or all of any nursing care that We determine does not require the skills of an R.N.; or
2. any nursing care given while the Covered Person is an inpatient in a health care facility, that could safely and adequately be furnished by that facility's general nursing staff if it were fully staffed.

14. PROSTHETIC DEVICES

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Doctor. Except for items required by the Women's Health and Cancer Rights Act of 1998, benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Except for items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Non-Network benefits for prosthetic devices is limited to $500 per Calendar Year. This limit applies to the total amount that We will pay for the prosthetics, and does not include any copayment or annual deductible responsibility the insured may have. Once the benefit limit is met, no additional benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.

15. REHABILITATION SERVICES – OUTPATIENT THERAPY

Benefits covered under this provision include short-term outpatient rehabilitation services for:

- Physical Therapy.
- Occupational Therapy.
- Speech Therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Doctor.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the condition of the insured within two months of the start of treatment.

Please note: We will pay benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke, or a congenital anomaly.

16. DURABLE MEDICAL EQUIPMENT

Covered Services for Durable Medical Equipment must meet the following criteria:

- Ordered or provided by a Physician for outpatient use;
- Used for medical purposes;
- Not consumable or disposable;
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost effective piece of equipment.

Durable Medical Equipment also includes hearing aids for a covered child under the age of eighteen if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a Physician and an audiological evaluation medically appropriate to the age of the child.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

We provide benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years. We will decide if the equipment should be purchased or rented. To receive Network benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify.

17. AMBULANCE SERVICE EXPENSES

This Plan pays the charges made by a professional ambulance service for:

1. the necessary air; water; or ground; transport of a Covered Person from the place where he or she has sustained an injury or is stricken by a disease to the nearest Hospital where treatment is given; and
2. the necessary non-emergency transfer of a Covered Person via ground ambulance or medical van.

Not covered are any charges made to transfer the Covered Person:

1. if ambulance service is not required by the Covered Person's physical condition;
2. if the type of ambulance service provided is not appropriate for the Covered Person's physical condition; and
3. via any form of transportation other than a professional ambulance service.

18. EMERGENCY ROOM SERVICES

We will pay for Covered Services incurred for Emergency Care due to an Illness or Injury for services Medically Necessary that do not result in Hospital Confinement. Emergency room benefits for an Illness will be paid for a Covered Person but will not exceed the overall Calendar Year maximum shown in the Summary of Benefits.

ADDITIONAL BENEFITS

1. Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:
a. All stages of the reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Benefits will be payable on the same basis as any other similarly covered Inpatient Facility Expense or medical-surgical Expense, as shown on the Summary of Benefits.

Prohibitions: We may not (a) offer the Covered Person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any Covered Person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the Physician or provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or provider to provide care to a Covered Person in a manner inconsistent with the coverage and/or benefits shown above.

Other Medical Expenses

1. Covered Services include charges incurred by a Covered Person for equipment, supplies and outpatient self-management training and education for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

   Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthodics.

   Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician includes:
   a. visits medically necessary upon the diagnosis of diabetes;
   b. visits under circumstances whereby a Physician identifies or diagnoses a significant change in the Covered Person's symptoms or conditions that necessitates changes in a Covered Person's self-management; and
   c. visits where a new medication or therapeutic process relating to the Covered Person's treatment and/or management of diabetes has been identified as medically necessary by a Physician.

2. Formulas that are equivalent to a prescription drug necessary for the therapeutic treatment of rare hereditary genetic metabolic disorders. As used in this provision: Rare hereditary genetic metabolic disorders are phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

3. The following charges when incurred by a Dependent child are included as Covered Services even though not incurred in connection with the treatment of a disease or injury.

   Children's Preventive Health Care Services

   Physician-delivered or physician-supervised services for eligible dependents from birth through age eighteen (18) years of age, with Periodic Preventive Care Visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section.

   Periodic Preventive Care Visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice, provided at the following age intervals:
   A. Birth;
   B. Two (2) weeks;
   C. Two (2) months;
   D. Four (4) months;
   E. Six (6) months;
   F. Nine (9) months;
   G. Twelve (12) months;
   H. Fifteen (15) months;
   I. Eighteen (18) months
   J. Two (2) years;
   K. Three (3) years;
   L. Four (4) years;
   M. Five (5) years;
   N. Six (6) years;
   O. Eight (8) years;
   P. Ten (10) years;
   Q. Twelve (12) years;
   R. Fourteen (14) years;
   S. Sixteen (16) years; and
   T. Eighteen (18) years.

   Benefits for recommended immunization services are payable at 100% with no deductible, copayment, coinsurance or maximum limit.

4. Covered Services include charges incurred for outpatient In Vitro Fertilization expenses, even though not incurred for treatment of a disease or injury by a female employee or by the dependent wife of a male employee. Expenses incurred for cryo preservation are also included.

   Benefits are provided on the same basis as any other illness if all of the following tests are met:
   a. The procedures are performed while she is not confined in a hospital or any other facility as an inpatient.
   b. Her oocytes are fertilized with her husband's sperm.
   c. She and her husband have a history of infertility which has lasted at least 2 years or the infertility is associated with one or more of these conditions.
      1) Endometriosis;
      2) Exposure in utero to diethylstilbestrol; known as DES;
      3) Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy; or
      4) Abnormal male factors contributing to the infertility.
   d. She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
   e. The in vitro fertilization procedures are performed:
      1) at a medical facility licensed or certified by the Arkansas Department of Health; or
      2) certified by the Arkansas Department of Health as either:
         a) meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
         b) meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

   Not more than the In Vitro Fertilization Maximum will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

5. Covered Services include charges incurred the necessary care and treatment of loss or impairment of speech or hearing payable on the same basis as any other illness.

   Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

   Coverage is not provided for hearing instruments or devices.

6. Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:
a. 48 hours following a mastectomy; and
b. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the Covered Person receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any Covered Person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any Covered Person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Covered Person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management Program uses the services of a Utilization Management Company to determine whether Covered Services are Medically Necessary. It is the Covered Person's responsibility to read and understand this benefit. The Covered Person should contact their Policyholder or customer service about how this program works.

The Utilization Management Program requires the cooperation of the Covered Person, Doctors, Providers, and Us. This program consists of medical review, medical case management, and Mental Illness and substance abuse reviews.

All Participating Providers have agreed to participate in the Utilization Management Program. This does not relieve the Covered Person of his responsibility to comply with all of the requirements of the Utilization Management Program.

For the Employee's assistance in contacting the Utilization Management Company, a toll-free number has been placed on each I.D. Card.

Following the review, the Utilization Management Company will issue written documentation to the Provider and the Covered Person which specifies the conditions of the authorization. Any payments for Covered Services are subject to all the terms and conditions of the Plan.

The ultimate decision as to whether any care should be received is between the Covered Person and the Doctor. If the Covered Person chooses to enter the Hospital or receive treatment without obtaining pre-authorization, Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of benefits will be reduced by 50%.

The Utilization Management Company may suggest the use of alternate forms of treatment or facilities which are not covered under the Plan. When this occurs, subject to Our approval, these expenses will be covered under the Plan on the same basis as the care and treatment for which they are substituted.

MEDICAL REVIEW PROGRAM

All Hospital admissions are subject to pre-authorization by a Utilization Management Company (UMC) selected by Us, and it is the Covered Person's responsibility to comply with all of the requirements of this program.

The Doctor, the Covered Person, or a member of his family must notify this organization as follows:

- Prior to a non-emergency admission;
- Within 24 hours, or on the first business day following an emergency admission.

The Utilization Management Company will review the applicable information and authorize:

- The Hospital admission, if it is Medically Necessary;
- The appropriate initial length of stay;
- Any extension beyond the original length of stay if it is Medically Necessary;
- An alternative course of treatment.

If pre-authorization is obtained, Eligible Expenses will be paid the same as any other Illness.

If pre-authorization for Hospital admissions is not obtained as stated above, benefits will be reduced after the Deductible Amount has been satisfied. Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of Benefits will be reduced by 50%.

MEDICAL CASE MANAGEMENT

Medical Case Management is intended to improve the effectiveness of health care by monitoring patient treatment plans and working directly with Doctors and patients to optimize care.

Medical Case Management is indicated only for patients who have diagnoses which typically require expensive or prolonged treatment, and which can frequently be optimized through a personal assessment. It takes physical, clinical, and psychosocial factors into consideration during the process.

Once a patient is determined to be a candidate for Medical Case Management, a case manager may perform any or all of the following:

1)Establish a working relationship with the patient's Doctors and other members of the health care team to assess the patient's needs;

2)Identify cost effective alternatives for treating the patient;

3)Develop a treatment plan that can maximize the patient's level of functioning.

SECTION 4: DESCRIPTION OF NETWORK AND NON-NETWORK BENEFITS

This section includes information about:

• Network Benefits.
• Non-Network Benefits.
• Emergency Care Services.

NETWORK BENEFITS

Network benefits are generally paid at a higher level than Non-Network benefits. Network benefits are payable for Covered Services which are either of the following:

- Provided by or under the direction of a Network Physician or other Network Provider in the Physician's office or at a Network facility.
- Emergency Care Services.

COMPARISON OF NETWORK AND NON-NETWORK BENEFITS

- Network benefits offer a higher level of benefits which means less cost to the Covered Person. See the Summary of Benefits.

- Non-Network benefits offer a lower level of benefits which means more cost to Covered Person. See the Summary of Benefits.

WHO SHOULD FILE CLAIMS

Network

Not required. We pay Network Providers directly.

Non-Network

The Employee must file claims. See Section: How to File a Claim.

PROVIDER NETWORK

Network Providers are independent practitioners. They are not Our Employees. It is each Employee's responsibility to select their Provider.

Before obtaining services, each Covered Person should always verify the Network status of a Provider. A Provider's status may change. A Provider's status can be verified by contacting customer service.

It is possible that a Covered Person might not be able to obtain services from a particular Network Provider. The network of Providers is subject to change. Or he/she might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to a Covered Person, he/she must choose another Network Provider to get Network benefits.

DESIGNATED FACILITIES AND OTHER PROVIDERS

A. If the Physician is a Network Provider, the Network Provider will notify Us of situations that might warrant a move to a designated facility or Non-Network facility or Provider if:
   1. The Covered Person has a medical condition requiring special service needs (including, but not limited to, transplants or cancer treatment); or
   2. The Covered Person requires certain complex Covered Services for which expertise is limited;

   Benefits will be paid at the Network level.

B. If the Physician is a Non-Network Provider, it is the Employee's responsibility to make sure We are notified of the above situations. If We are not notified in advance and if services are received from a Non-Network facility (regardless of whether it is a designated facility) or other Non-Network Provider, Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of Benefits for Non-Network Benefits will be reduced by 50%. Non-Network Benefits will be available if the special needs services received are Covered Services for which Benefits are provided under the Policy.

HEALTH SERVICES FROM NON-NETWORK PROVIDERS PAID AS NETWORK BENEFITS

If specific Covered Services are not available from a Network Provider, the Covered Person may be eligible for Network Benefits when Covered Services are received from Non-Network Providers. In this situation, the Network Physician will notify Us, and we will work with the Covered Person and his/her Network Physician to coordinate care through a Non-Network Provider. If We authorize care through the Non-Network Provider, benefits would be paid as if the services were received from a Network facility or provider.

CONTINUITY OF CARE

If the Covered Person is under the care of a Network Provider for one of the medical conditions below, and the Network Provider caring for him/her is terminated from the Network by Us, we can arrange, at the Covered Person's request and subject to the Provider's agreement, for continuation of Covered Services rendered by the terminated Provider as a Network Benefit.. Medical conditions and time periods for which treatment by a terminated Network Provider will be covered under the Plan as a Network Benefit are:

- A life-threatening illness. Treatment by the terminated Provider may continue as a Network Benefit until the course of treatment is complete, not to exceed three months from the effective date of termination.
- A high risk Pregnancy or a Pregnancy that is past the twenty-fourth week of Pregnancy. Treatment by the terminated Provider may continue as a Network Benefit until the postpartum services related to the delivery are complete. For the purposes of this section "life-threatening illness" means a severe, serious, or acute condition for which death is probable.

This section does not apply when:

- The reason for such termination is due to suspension, revocation, or applicable restriction of the health care Provider's license to practice in this state, or for another documented reason related to quality of care.
- His/Her choice to change health care Providers.
- The Covered Person moves out of the geographic service area of the health care Provider.
- The Covered Person requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

NON-NETWORK BENEFITS

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Services which are either of the following:

- Provided by Non-Network Providers.
- Provided under the direction of a Non-Network Physician at a Non-Network facility or program.

PRE-AUTHORIZATION REQUIREMENT

A Covered Person must obtain prior authorization from Us before getting certain Covered Services from Non-Network Providers. For more information, the Covered Person may contact customer service

Prior authorization does not mean Benefits are payable in all cases. Coverage depends on the Covered Services that are actually given, the eligibility status, and any benefit limitations.

NON-NETWORK EMERGENCY CARE SERVICES

Subject to the Deductible, we will provide Benefits for Emergency Care Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Care Services, even if the services are provided by a Non-Network Provider. Emergency Care services will be provided as a Network Benefit until the Covered Person can reasonably be expected to be transferred to Network Provider. If the Covered Person is confined in a Non-Network Hospital after receiving Emergency Care Services, We request notification within one business day or on the same day of admission if reasonably possible. No penalty will be assessed the Covered Person if notification is not given within these time frames if it is shown that it was not reasonably possible to do so. In any event, notification should be provided to Us as soon as is reasonably possible. We may elect to transfer the Covered Person to a Network Hospital as soon as it is medically appropriate to do so. If the Covered Person chooses to stay in the Non-Network Hospital after the date we decide a transfer is medically appropriate, Non-Network Benefits will be available if the continued stay is determined to be a Covered Service.

EMERGENCY CARE SERVICES includes a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is necessary to determine whether a medical emergency condition exists; necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and services originating in a Hospital emergency facility following treatment or stabilization of an emergency medical condition.

SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS

Services and supplies are not covered if they are:

1. not Medically Necessary;
2. in excess of the Maximum Allowable Charge;
3. not prescribed, recommended or approved by a Physician;
4. not furnished within the scope of the Physician's license;
5. furnished while the person is not a Covered Person by the Policy;
6. provided to the Covered Person or insurer with no legal obligation to pay;
7. furnished by a government plan or facility, unless the Covered Person is legally obligated to pay (except Medicaid and mental health benefits and mental retardation benefits provided by a tax supported institution);
8. for Custodial Care solely for personal needs, comfort or convenience of the Covered Person;
9. to control the Covered Person's environment;
10. provided by the immediate family;
11. provided mainly for education, training or vocational rehabilitation or counseling; or
12. not specifically included as a Covered Service or specifically excluded as not covered by the Plan.

Benefits are not provided for Expenses incurred from:

1. Injury or Sickness:
   a. arising out of or in connection with employment or occupation for wage or profit;
   b. covered or eligible for coverage under Workers' Compensation or any occupational disease, employer's liability or similar law,
   c. caused by an act of declared or undeclared war;
   d. occurring while on active duty with any military, naval or air force of any country or international organization, except this will not apply to orders for active service for training purposes of two month or less;
   e. resulting from the Covered Person's participation in an assault or felony, or while engaged in an illegal occupation;
   f. resulting from intentionally self-inflicted Injury, suicide or attempted suicide;
   g. resulting from voluntary taking of any gas or poison or voluntary taking of any drug, sedative, or narcotic unless prescribed by a Physician and taken according to the prescribed dosage;
   h. resulting from driving a motor vehicle while legally intoxicated according to the laws of the state where the Injury occurs;
   i. occurring while outside of the United States;

2. Procedures or devices that are:
   a. in a research or experimental stage;
   b. considered as Experimental or Investigational by the protocol of the U. S. Department of Health and Human Services or any of its agencies;
   c. not generally accepted as effective treatment by the U. S. medical community;
   d. primarily used in a laboratory or research setting that has progressed to only limited human use; or
   e. not of demonstrated value for the diagnosis and treatment of an Injury or Sickness;

3. Drugs and medicines that are:
   a. not prescribed by a Physician, or that are not approved by the U. S Food and Drug Administration;
   b. over-the-counter medications of any kind except for medications for the treatment of diabetes;
   c. nutritional supplements, minerals and vitamins, such as, but not limited to, pre-natal vitamins. This exclusion does not apply to formulas for the therapeutic treatment of rare hereditary genetic metabolic disorders;
   d. growth hormones;
   e. determined to be "less than effective" by the Drug Efficiary Study Implementation (DESI) Program;
   f. fertility agents;
   g. for cosmetic use including, but not limited to Retin-A for a Covered Person age 25 and over;
   h. anti-smoking aids, such as, but not limited to, Nicorette Gum;
   i. Dexadrine for a Covered Person over the age of 18;
   j. used to treat or cure baldness, such as, but not limited to, Rogaine or Monoxidil; or
   k. outpatient prescriptions;

4. Hospital admission from Friday 8:00 A.M. through Monday 12:01 A.M. unless surgery is performed within 24 hours of the admission, or because of an emergency;

5. Hospital Confinement that is not Medically Necessary and is solely for the convenience of the Covered Person or Physician;

6. Cosmetic surgery, which term includes but is not limited to:
   a. surgery to the upper and lower eyelid;
   b. augmentation mammoplasty;
   c. full or partial facial lifts;
   d. dermal or chemo abrasion;
   e. scar revision;
   f. otoplasty;
   g. lift, stretch or reduction of abdomen, buttocks, thighs or upper arm;
   h. silicone injections to any part of the body; and
   i. rhinoplasty;

   unless such surgery is required for a condition resulting from congenital defects or birth abnormalities of a newborn child or from Injury, and (except for a newborn child) such Injury occurred while the Covered Person was insured under the Plan;

7. Dental services or supplies, except for the following procedures:
   a. to repair damage to sound natural teeth Accidentally injured while the person is a Covered Person and the repair is done within 12 months from the date of the Injury;
   b. to remove impacted, unerupted teeth;
   c. Reconstructive Surgery for Craniofacial Abnormalities for dependent children under age 18; and
   d. Anesthesia and dental care in a hospital or ambulatory surgical center for a covered person for which the provider treating the patient certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and who:
      (1) is a child under age seven who is determined by two licensed dentists, to require without delay necessary dental treatment for a significantly complex dental condition; or
      (2) is a person with a diagnosed serious mental or physical condition; or
      (3) is a person with a significant behavioral problem as determined by the Covered Person's physician.

8. Eye exams, testing for refraction, eye or visual exercises, vision therapy, or contact lenses or eyeglasses;

9. Radial keratotomy or other surgery to correct or change refractive defects of the eye;

10. Injury resulting from travel, flight in, or descent from any aircraft owned or leased by the Covered Person, or being in any aircraft being used for one or more of the following:
    a. test or experimental purposes;
    b. speed test;
    c. exhibition or stunt flying;
    d. crop dusting or seeding;
    e. hunting, herding or herd thinning; or
    f. fire fighting;

11. Injury while riding in or on a motorized vehicle of any type designed for or primarily used for racing, speed tests, or hazardous exhibition purposes;

12. Injury while engaging in any of the following hazardous activities:
    a. hang gliding or flying an ultra light aircraft;
    b. skydiving; or
    c. scuba diving;

13. Services or supplies for:
    a. diagnosis and testing of fertility or infertility other than In Vitro Fertilization;
    b. reversal of sterilization procedure; or
    c. artificial insemination;

14. Transsexual surgery or other sex modification procedures and any related complications;

15. Marriage counseling and any therapy or counseling for sexual dysfunctions;

16. Weight loss treatment or supplies of any kind, including but not limited to:
    a. gastric bypass, gastroplasty, or gastric stapling, regardless of Physician's recommendation for medical necessity;
    b. balloon catheterization;
    c. diet or exercise programs;
    d. weight reduction programs or clinics; or
    e. liposuction or reconstructive surgery other than reconstructive surgery for Mastectomy and Craniofacial Abnormalities;

17. Exercise equipment or programs regardless of their purpose;

18. Purchase of home based artificial kidney equipment;

19. Treatment or supplies of any kind for routine foot care for (except with respect to diabetic care):
    a. paring or removal of corns, calluses or toenails;
    b. instability or imbalance of the feet; or
    c. orthopedic shoes, orthoses and other supportive devices for the feet, except if needed for conditions resulting from diabetes;

20. Acupuncture, acupressure or massage therapy;

21. Charges for failure to keep an appointment, or to complete claims forms;

22. Hospital confinement for physical therapy, rehabilitation, diagnostic x-ray and laboratory services or other diagnostic studies, except when such care or services cannot be rendered on an outpatient basis;

23. Charges for biofeedback services;

24. Charges for any maintenance type therapy not reasonably expected to improve the patient's condition;

25. Charges for:
    a. any service or supply in connection with an organ transplant, except a human to human organ transplant;
    b. any transplant which is sold rather than donated to the Covered Person; or
    c. any service or supply in connection with autologous bone marrow transplantation for treatment of any disease other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, and neuroblastomas;

26. Treatment, services or supplies for any of the following except if described as a Covered Service by the Policy:
    a. Home Health Care;
    b. abortion unless the life of the mother would be threatened if the fetus were carried to term;
    c. pre-employment or pre-marital examinations;
    d. in vitro, in ovum fertilization or Gamete Intrafallopian Transfer (GIFT);
    e. hearing aids, implants, their fitting, and related hearing tests and exams.

27. Breast reductions are excluded regardless of the Physician's recommendation of Medical Necessity except in connection with Breast Reconstructive Surgery after a covered mastectomy; or

28. In connection with a Genetic Test or chromosome analysis.

29. Charges for a Pre-Existing Condition, except as provided in the Covered Services section of the Plan.

30. Osteotomies, chelation therapy and orthomolecular medicine.

SECTION 6: TERMINATION OF COVERAGE

Termination of the Policy: The Policyholder may terminate the Policy by providing written notice to Us at least 30 days prior to termination. We may terminate the Plan on any date if:

1. The Policyholder fails to pay the premiums as required by the terms of the Plan;
2. The Policyholder has committed fraud or intentional misrepresentation of a material fact;
3. On the first renewal date following the end of a six month consecutive period during which the qualifying minimum participation requirement was not met; or;
4. The Policyholder fails to meet the required contribution requirements.

Termination of Covered Persons:

For the Employee, insurance terminates on the earliest of the following:

1. The date the Plan terminates;
2. The date any benefit of the Plan terminates, in regard to that benefit;
3. The date the Employee cancels insurance;
4. The date the Policyholder cancels insurance for the Employee. The Policyholder must give advanced written notice at least 31 days prior to the date the insurance ends;
5. The date premiums are not paid when due, subject to the Grace Period provision;
6. The date the Employee's employment is terminated;
7. The date the Employee enters full-time military service. For purposes of this insurance, active military service for training purposes of two months or less is not full-time service; or
8. The date the Employee commits fraud upon Us or intentionally misrepresents a material fact which affects his coverage under the Plan.

For the insured **Dependent**, insurance terminates of the earliest of the following:

1. The date the Employee's coverage terminates;
2. The date any benefit of the Plan terminates for the insured Dependent, in regard to that benefit;
3. The date the Employee cancels the insured Dependent's insurance;
4. The date the Policyholder cancels insurance for dependents. The Policyholder must give advanced written notice at least 31 days prior to the date the insurance ends;
5. The date premiums are not paid when due for the insured Dependent, subject to the Grace Period provision;
6. The date the insured Dependent no longer meets the definition of Dependent except that coverage for a grandchild will not terminate solely because grandchild is no longer a Dependent of the Employee for federal income tax purposes.
7. With respect to the Employee's spouse, the date the Employee is divorced from such spouse;
8. The date the insured Dependent commits fraud upon Us or misrepresents a material fact which affects his coverage under the Plan; or
9. The date the insured Dependent enters full-time military service. For purposes of this insurance, active military service for training purposes of two months or less is not full-time service.

Notwithstanding the above, in the event a Covered Person ceases to be eligible for coverage, and the Policyholder fails to report to Us the termination of coverage of the person at least 30 days prior to the pending termination date, coverage will continue for the Covered Person until the end of the month in the Policyholder notifies Us that the Coverage Person is no longer eligible for coverage. The Policyholder will be liable for all premiums for such coverage.

LIMITED EXTENSION DUE TO TOTAL DISABILITY

A Covered Person's benefits will continue to be payable under the Plan when the Policy terminates, if he;

A. Is Totally Disabled; and
B. Is confined to a Hospital for the disabling Illness or Injury at the date the Policy would otherwise terminate.

Benefits paid under this extension will be paid until the earliest of these dates:

A. The date which is ninety (90) days from the date coverage would have otherwise terminated; or
B. The date the Covered Person is no longer Hospital confined; or
C. The date on which the disabled person's Medical Benefit has reached the applicable maximum under the Plan.

This extension of coverage applies only to the disabled person and no premium is due.

SECTION 7: COORDINATION OF BENEFITS

This section applies if You are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If You are covered by more than one health benefit plan, You should file all claims with each plan.

A. Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

Plan
Any of the following that provides benefits or services for medical care or treatment with which coordination is allowed:

1. Group insurance and group subscriber contracts;
2. uninsured arrangements of group or group-type coverage;
3. group or group-type coverage through HMOs and other prepayment, group practice, and individual practice plans;
4. group-type contracts which are contracts that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.
5. the amount by which group or group-type hospital indemnity benefits exceed $100 per day;
6. the Medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and
7. Medicare or other governmental benefits, except a state plan under Medicaid. That part of the definition of "plan" may be limited to the hospital, medical, and surgical benefits of the governmental program.

Each type of coverage You have in the above categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefits rules, each of the parts shall be treated as a separate Plan.

Plan does not include any of the following:

1. individual or family insurance contracts;
2. individual or family subscriber contracts;
3. individual or family coverage through health maintenance organizations (HMOs);
4. individual or family coverage under other prepayment, group practice, and individual practice plans;
5. group or group-type hospital indemnity benefits of $100 per day or less;
6. school accident-type coverages which cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; and
7. a state plan under Medicaid;
8. plans when, by law, their benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Primary Plan.

A plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A plan is a "primary plan" if either of the following conditions is true:

1. the plan either has no order of benefit determination rules, or
2. it has rules which differ from those permitted by this subchapter.

There may be more than one "primary plan"; or all plans which cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan
A plan which is not a "primary plan." If a person is covered by more than one "secondary plan," the order of benefit determination rules of these sections decide the order in which their benefits are determined in relation to each other. The benefits of each "secondary plan" may take into consideration the benefits of the "primary plan" or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that "secondary plan.

Allowable Expense

The necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

Examples of expenses or services that are not an Allowable Expense include, but are not limited to the following:

1. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
2. The difference between the cost of a private Hospital room and the cost of a semi-private hospital room is not considered an "allowable expense" under this section unless the covered person's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.
3. If You are covered by two or more Plans that provide services or supplies on the basis of usual and customary fees, any amount in excess of the highest usual and customary fee is not an Allowable Expense.
4. When benefits are reduced under a primary plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an "allowable expense." Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.
5. When a plan provides benefits in the form of service, the Reasonable Cash Value of each service will be considered as both an "allowable expense" and a benefit paid.

Claim Determination Period
A calendar year, but it does not include any part of a year during which You are not covered under this Agreement or any date before this section or any similar provision takes effect.

Reasonable Cash Value
An amount which a duly licensed Provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care Providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

B. Order of Benefit Determination Rules

A primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. A secondary plan may take the benefits of another plan into account only when, under this subchapter, it is secondary to that other plan.

In determining the order of benefit, the first of the following rules will applies.

1. The benefits of the plan which covers the person as an Employee, member, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent. There is one exception. If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired Employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.
2. With respect to a dependent child whose parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. As used in this paragraph, the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born. If the plan does not have the rule based upon the parent's birthday, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon gender of the parent will determine the order of benefits.
3. With respect to a dependent child whose parents are separated or divorced, where two or more plans cover the child, benefits for the child are determined in this order:
    a. first, the Plan of the parent with custody of the child;
    b. Then, the Plan of the spouse of the parent with the custody of the child; and
    c. finally, the Plan of the parent not having custody of the child.
    d. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
    e. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (2) of this subsection.

4. With respect to active as related to inactive Employees, the benefits shall be determined in the following order. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's dependent) are determined before those of a plan which covers that person as a laid off or retired Employee (or as that Employee's dependent). If the other Plan does not have this rule; and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. With respect to continuation coverage, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
   a. first, the benefits of a plan covering the person as an Employee, member, or subscriber (or as that person's dependent);
   b. second, the benefits under the continuation coverage.
   c. If the other plan does not have the rule described in subparagraphs a. and b. of this paragraph, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
6. Where none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term.
   a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
   b. The start of a new plan does not include:
      (i) a change in the amount or scope of a plan's benefits;
      (ii) a change in the entity which pays, provides, or administers the plan's benefits; or
      (iii) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
   c. The person's length of time covered under a Plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a member of the group will be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

C. Effect on the Benefits of this Agreement

If we are the Secondary Plan, we may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses.

The difference between the benefits payments that we would have paid had we been the Primary Plan and the benefit payments that we actually paid as the Secondary Plan shall be recorded as a benefit reserve for You. We will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

If there is a benefit reserve, we shall use the benefit reserve recorded for You to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, Your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination.

D. Recovery of Excess Benefits

If we provide Services and Supplies that should have been paid by the primary Plan or if we provide services in excess of those for which we are obligated to provide under this Agreement, we shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We shall have the sole discretion to seek such recovery from any person to, or from whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If we request, You shall execute and deliver to such instruments and documents as we determine are necessary to secure its rights.

E. Right to Receive and Release Information

We, without consent of or notice to You, may obtain information from and release information to any Plan with respect to You in order to coordinate Your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate Your benefits pursuant to this section.

SECTION 8:
THIS PROVISION IS SUBJECT TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) AND ALL SUBSEQUENT LAWS EFFECTING THIS ACT.

This provision applies to a Policyholder with twenty (20) or more Employees on a typical business day during the preceding Calendar Year if group health coverage was provided to Employees.

Introduction

You are receiving this notice because You have recently become covered under a group health plan (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Plan and under Federal Law, You should review the Policy or Certificate of Coverage or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualifying beneficiary". You, Your spouse, and Your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
-

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "Dependent child".

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Policyholder must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or a Dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of an Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability extension of 18 month period of continuation coverage

If Your or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage.

Second qualifying event extension of 18 month period of continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare (under Part A, Part B, or both), or gets divorced or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

SECTION 9: CONTINUATION OF COVERAGE

As an alternative to continuation of coverage under COBRA, the following continuation provisions are available to the following Covered Persons:

- Employees whose coverage ends for any reason other than termination of this policy or termination of the class in which the employee was insured.
- The surviving spouse or divorced spouse of an employee whose coverage would otherwise terminate as a result of the divorce or the death of the employee.

Continuation is not available to:

- Employees whose coverage ends because of failure to pay any required contribution towards the cost of their coverage under the policy.
- Covered Persons who are eligible for Medicare.
- Covered Persons whose coverage is replaced by another group medical plan within 31 days after coverage under this policy terminates.
- Covered Persons who have not been insured for at least three months on the date their coverage under this policy ends.

Continuation of coverage is subject to payment of premium to the Policyholder by the Covered Person. The premium will be the amount of premium the Policyholder would pay for the coverage if the Covered Person was insured under this policy in the absence of this continuation provision, including amounts paid towards premium by the Policyholder and by the employee.

Coverage under this policy may be continued for up to 120 days after the month in which coverage under this policy would otherwise terminate except:

- Covered Persons whose coverage would end as a result of the divorce or death of the employee may continue coverage for up to 15 months after the end of the month in which coverage under this policy would otherwise terminate. Such continuation is subject to the Covered Person paying premium to the Policyholder in advance in three month increments.
- Covered Persons who are pregnant when coverage under this policy would otherwise terminate may continue coverage subject to the Covered Person paying premium to the Policyholder in advance in three month increments. Coverage may be continued for up to six months after the pregnancy ends, or if longer, the end of the second three month period following the three month period in which the pregnancy ends.

A Covered Person is eligible for Conversion at the end of this continuation period.

SECTION 10 – CONVERSION

Any Employee whose insurance under this Policy has been terminated for any reason, including discontinuance of this Policy in its entirety or discontinuance of an insured class will be entitled to have issued by Us an individual policy of health insurance (hereafter referred to as the "converted policy"). This provision only applies to individuals whose coverage terminates at the end of any COBRA or state continuation provision provided in the Policy. The converted policy may provide levels which are substantially similar to those provide under this Policy.

A Employee will not be entitled to have a converted policy issued if termination of the insurance under this Policy occurred for any of the following reasons:

a. the Employee failed to pay any required contribution;

b. any discontinued group coverage was immediately replaced by similar group coverage unless such person was declined coverage under the replacing group coverage; or

c. The person is, or could be, covered for Medicare benefits or similar benefits provided by any state or federal law, similar benefits provided on a group or individual basis or any benefits provided above which, together with the benefits provided under the conversion policy, would result in over-insurance.

Written application for the converted policy must be made and the first premium paid to Us not later than thirty-one (31) days after such termination. The converted policy will be issued without evidence of insurability.

The effective date of the converted policy will be the day following the termination of insurance under this Policy. The converted policy will cover the Employee and any dependents who were covered by this Policy on the date of termination of insurance.

This conversion privilege may be exercised at the Employee’s option at the end of any COBRA or state continuation of coverage provision provided under the group policy and will be available to the following:

1. the surviving spouse, if any, of the Employee with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or

2. the spouse of the Employee with respect to the spouse and children whose coverage terminates because the spouse ceases to be a qualified family member and while the Employee remains insured under the group policy, or

3. a child solely upon termination of the coverage by reason of ceasing to be a qualified family member under the group policy, or

4. the former spouse whose coverage under the group policy terminates by reason of an entry of a valid decree of divorce between the insured and spouse.

SECTION 12: GENERAL PROVISIONS

CALCULATION OF PREMIUM

On the Plan's Effective Date, the monthly premium for coverage on Employees and, if applicable, Dependents will be based on the rates shown on the Policyholder's Application for Insurance under the Plan.

We will have the right to change the premium rates or the basis on which premiums are calculated:

A. On any Plan Anniversary; or
B. On any premium due date; but not before the first Policy Anniversary and not more than once every six (6) months after the first Policy Anniversary.

We will provide written notice of any rate increase to the Policyholder at least sixty (60) days before the date the rate increase is to take effect. The rate then being charged must have been approved by Us. Any time period in which a rate must stay in effect will be shown in the Policyholder's Application.

HOW PREMIUMS ARE PAYABLE

Premiums must be paid in advance to Us at the Home Office in New Orleans, Louisiana. Premiums may also be paid to Our authorized agent in exchange for Our receipt signed by Our Officer and countersigned by the agent as evidence of such payment. Premiums may be paid as indicated on the Application. Upon written request to Us, the mode of premium payments may be changed on any Plan Anniversary with proper adjustments. The payment of any premium will not continue the Plan in force beyond the date the next premium is due, except for Grace Period provision.

GRACE PERIOD FOR PAYMENT OF PREMIUMS

If the Policyholder has not given written notice to Us to cancel the Plan, a Grace Period of at least thirty-one (31) days will be allowed after the due date for the payment of each premium after the first. The Plan will continue in force during this period. If the premium is not paid before the end of the Grace Period the Plan will cease on the last day of the Grace Period. All valid claims will be paid for a loss incurred before the expiration of the Grace Period. A pro-rata premium will be due for the Grace Period.

If, before the end of the Grace Period, the Policyholder gives written notice to Us at Our Home Office that the Plan is to be cancelled, the Plan will terminate on the effective date of such notice. A pro-rata premium will be paid for the period between the date the premium was due and the date the Plan ends.

ASSIGNMENT

The coverage provided hereunder is assignable.

CANCELLATION

All or any part of the coverage provided under the Plan may be cancelled by the Policyholder by mailing to Us written notice at least thirty-one (31) days prior to the cancellation date. If the Policyholder cancels this plan, the coverage will end at 12:00 midnight on the last day of the policy month following the required notice period.

Delivery of written notice by either the Policyholder or Us shall be equivalent of mailing.

CONFORMITY WITH STATE STATUTES

Any provision of the Plan which, on its Effective Date, is in conflict with the statutes of the state in which the Plan was issued is hereby amended to conform to the minimum requirements of such statutes, unless otherwise forbidden by the laws of the state where the Covered Person lives.

INADVERTENT ERROR

The Covered Person will not lose the amount of coverage due to him because of error or failure by the Policyholder:

A. To give the name of a Covered Person who has qualified and made the proper payment for coverage; or
B. To report a change in the amount of coverage shown in the Policy or Certificate.

In the event of the Policyholder fails to report the termination of coverage of any Covered Person, the Policyholder will be liable for a Covered Person's premium from the time the Covered Person is no longer part of the group eligible for coverage until the end of the month in which the Policyholder notifies Us that the Coverage Person is no longer eligible for coverage.

INCONTESTABILITY OF PLAN

We will not contest the Plan after it has been in force for two (2) years, except:
A. For nonpayment of premium; or
B. For fraudulent misstatements or intentional misrepresentation of a material fact by the Policyholder.

No statement made by a Covered Person relating to his insurability will be used to contest his coverage:
A. After his coverage has been in force during his lifetime for two (2) years prior to the contest; and
B. Unless such statement is in writing and signed by him.

LEGAL ACTIONS

No legal action will be brought to recover under the Plan:

A. Until sixty (60) days have elapsed after proof of claim has been filed; or
B. After three (3) years from the end of the time within which proof of claim is required by the Plan.

MODIFICATION CAN BE MADE ONLY BY AN OFFICIAL

Only Our President, Vice-President, the Secretary or an Assistant Secretary can change or waive any provision of the Plan. Any changes must be made in writing. We will not be bound by any promises or representations made by an agent or anyone other than the above.

PLAN AND APPLICATION CONSTITUTE ENTIRE CONTRACT

The Plan, Application of the Policyholder for coverage under the Plan, and the Employee's' Enrollment Forms form the entire contract between the parties. All statements made by the Policyholder or by the Employee will be deemed representations and not warranties. No statement made by the Policyholder, the Employee, or his Dependent will be used in any contest unless a copy of the instrument containing such statement is or has been furnished to the Employee.

PRONOUNS

Masculine pronouns used in the Plan will apply to both sexes.

RECORDS OF THE POLICYHOLDER

The Policyholder will give such data as may be required by Us to provide the coverage. This includes data on Covered Persons becoming covered, changes in the amount of coverage and terminations of coverage. Payroll and other personnel records pertaining to coverage under the Policyholder's Plan will be open for review by Us at any reasonable time. Any additional records of the Policyholder as may have a bearing on the coverage shall also be open for review by Us at any reasonable time. The Covered Person will not lose the amount of coverage due him because of error or failure by the Policyholder:

A. To give the name of a Covered Person who has qualified and made the proper payment for coverage; or
B. To report a change in the amount of coverage shown in the Policy or Certificate.

Failure to report the termination of coverage of any Covered Person will not continue the coverage beyond the date of termination shown in the Policyholder's Plan.

WORKER'S COMPENSATION

The Plan is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.

RIGHT OF SUBROGATION

Subrogation means We have the right to request a refund of payments made by Us under the following conditions:

We will be subrogated to any claim a Covered Person has against a third party provided:

A. The Covered Person was injured or became ill due to the act or omission of the third party, and
B. We paid benefits to the Covered Person under the Plan for such Injury or Illness.

If the Covered Person collects any sums for damages from the third party, the Covered Person will be liable to Us for the benefits We paid. If the Covered Person sues to recover his expenses from a third party, We can join in the suit. If the Covered Person does not sue, We can do so in the name of the Covered Person.

The Covered Person is obligated to:

A. Avoid doing anything that would prejudice Our right of subrogation; and
B. Execute any documents reasonably required to enforce Our right.(Failure to execute the required documents does not waive our rights to collect any sums for damages from the third party.)

SECTION 13: UNIFORM CLAIMS PROVISION

NOTICE OF CLAIM

Written notice of claim must be given to Us within twenty (20) days after the date any Injury or Illness occurs or begins. If notice is not furnished within the time limit stated above, a claim will still be considered for payment and will not be denied or reduced due to the delay if it is shown that notice was given as soon as was reasonably possible.

CLAIM FORMS

We will furnish forms for filing proof of claim after We get the notice of claim. If such forms are not furnished within fifteen (15) days of receipt of the notice, the claimant will be deemed to have met with the terms of this provision of the Plan if he submits written proof of claim within the time set forth in the Proof of Claim provision.

PROOF OF CLAIM

Written proof of claim must be given to Us within ninety (90) days after the date of treatment.

However, the claim will not be denied or reduced if:

1. It is not reasonably possible to give proof in that time; and
2. Proof is submitted within one (1) year from the date of Loss or treatment.

This one (1) year period will not apply when the Covered Person is legally incapable of submitting proof. All proofs of claim must be satisfactory to Us.

TIME PAYMENT OF CLAIMS

Benefits payable under the Plan will be paid immediately after receipt of due written proof of claim. If all essential information needed to make a determination on the claim is not received, then the thirty (60) days will not be effective until all required information is received by Us.

PHYSICAL EXAMINATION

We, at Our own expense, will have the right to have a Covered Person examined as often as We may reasonably require, while a claim is pending.

How to File a Claim

This section provides the Employee with information about:

- How and when to file a claim.
- If the Covered Person receives Covered Services from a Network Provider, the Employee does not have to file a claim. We pay these Providers directly.
- If the Covered Person receives Covered Services from a Non-Network Provider, the Employee is responsible for filing a claim.

If the Covered Person Receives Covered Services from a Network Provider

We pay Network Providers directly for Covered Services. If a Network Provider bills the Employee for any Covered Health Service, contact Us. However, the Employee is responsible for meeting the Deductible.

If the Covered Person Receives Covered Services from a Non-Network Provider

When a Covered Person receives Covered Services from a Non-Network Provider, the Employee is responsible for requesting payment from Us. The Employee must file the claim in a format that contains all of the information we require, as described below.

The Employee must submit a request for payment of benefits within 90 days after the date of service. If the Employee does not provide this information to Us within one year of the date of service, benefits for that health service will be denied or reduced, according to the terms of the policy. This time limit does not apply if the Employee is legally incapacitated. If the claim relates to an inpatient stay, the Employee must request payment of benefits within 90 days of the date of release from the Hospital.

We will pay benefits directly to a Physician or other health care provider, and will be relieved of the obligation to pay, and of any liability for paying, those benefits to the Covered Person if:

1. the Covered Person makes a written assignment of those benefits payable to the Physician or other health care provider; and
2. the assignment is obtained by or delivered to Us with the claim for benefits.

Required Information

When requesting payment of benefits from Us, the following must be provide to Us with all of the following information:

A. The Covered Person's name and address.
B. The patient's name and age.
C. The number stated on his/her ID card.
D. The name and address of the Provider of the service(s).
E. A diagnosis from the Physician.
F. An itemized bill from the Provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
G. The date the Injury or Sickness began.
H. A statement indicating either that the Covered Person is or is not, enrolled for coverage under any other health insurance plan or program.

If the Covered Person is enrolled for other coverage, the Employee must include the name of the other carrier(s).

Payment of Benefits

You may not assign Your Benefits under the Plan to a non-Network Provider without our consent. We may, however, in our discretion, pay a non-Network Provider directly for services rendered to You.

SECTION 14: CLAIMS AND APPEAL NOTICE

Benefit Determinations

Post-service Claims
Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If Your post-service claim is denied, You will receive a written notice from us within 15 business days of receipt of the claim, as long as all needed information was provided with the claim. We will notify You within this 15 business day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend Your claim until all information is received. Once notified of the extension, You then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is determined to be eligible for payment, the claim will be paid immediately. If the claim is determined not eligible for payment and is denied, we will notify You of the denial within 15 days.

If You do not provide the needed information within the 45-day period, Your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Pre-authorization Requests for Benefits

Pre-authorization requests for Benefits are those requests that require authorization prior to receiving medical care. If You have a pre-authorization request for Benefits, and it was submitted properly with all needed information, You will receive notice of the decision from us. We will mail or otherwise transmit such notice to You and to Your Physician not later than 3 calendar days of receipt of the request. If additional information is needed to process the pre-authorization request, we will notify You of the information needed within 3 calendar days after it was received, and may request a one time extension not longer than 15 days and pend Your request until all information is received. Once notified of the extension You then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify You of a non-adverse determination within 2 working days after the information is received. We will notify You of an adverse determination within 3 working days after the information is received If You don't provide the needed information within the 45-day period, Your request for Benefits will be denied. A denial notice of an adverse determination will include:
(1) the principal reasons for the adverse determination;//
(2) the clinical basis for the adverse determination;
(3) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and
(4) a description of the procedure for the complaint and appeal process, including notice to You of Your right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations: • You will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written or electronic confirmation to follow within three days. If You filed an urgent request for Benefits improperly, we will notify You of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify You of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information. You will be notified of a benefit determination no later than 48 hours after:
• Our receipt of the requested information; or
• The end of the 48-hour period within which You were to provide the additional information, if the information is not received within that time. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and Your request to extend the treatment is an urgent request for Benefits as defined above, Your request will be decided within 24 hours, provided Your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on Your request for the extended treatment within 24 hours from receipt of Your request. If Your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and You request to extend treatment in a non-urgent circumstance, Your request will be considered a new request and decided according to post-service or pre-authorization timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If You have a question or concern about a benefit determination, You may informally contact our customer service department before requesting a formal appeal. If the customer service representative cannot resolve the issue to Your satisfaction over the phone, You may submit Your question in writing. However, if You are not satisfied with a benefit determination as described above, You may appeal it as described below, without first informally contacting a customer service representative. If You first informally contact our customer service department and later wish to request a formal appeal in writing, You should again contact customer service and request an appeal. If You request a formal appeal, a customer service representative will provide You with the appropriate address. If You are appealing an urgent claim denial, please refer to the *Urgent Appeals that Require Immediate Action* section below and contact our customer service department immediately.

How to Appeal a Claim Decision

If You disagree with a pre-authorization request for Benefits determination or post-service claim determination after following the above steps, You, your Physician, a person acting on your behalf, or other healthcare provider can contact us orally or in writing to formally request an appeal.
The request should include:
• The patient's name and the identification number from the ID card.
• The date(s) of medical service(s).
• The Provider's name.
• The reason You believe the claim should be paid.
• Any documentation or other written information to support Your request for claim payment. Within five working days from the date We receive the appeal, We will send You a letter acknowledging the date of receipt. The letter will include a list of:
(1) the procedures for appeal; and
(2) the documents that the appealing party must submit for review

When We receive an oral appeal of an adverse determination, We will send a one-page appeal form to the appealing party.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If Your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Upon request and free of charge, You have the right to reasonable access to and copies of all documents, records, and other information relevant to Your claim for Benefits.

Appeals Determinations

Pre-authorization Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on Your appeal as follows:

• For appeals of **pre-authorization requests for Benefits** as identified above, the first level appeal will be conducted and You will be notified of the decision within 3 calendar days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and You will be notified of the decision within 3 calendar days from receipt of a request for review of the first level appeal decision.

• For appeals of **post-service claims** as identified above, the first level appeal will be conducted and You will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and You will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision. For procedures associated with urgent requests for Benefits, see *Urgent Appeals That Require Immediate Action* below. If You are not satisfied with the first level appeal decision, You have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. Please note that our decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between You and Your Physician.

Urgent Appeals that Require Immediate Action 4207.357

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:
• The appeal does not need to be submitted in writing. You or your physician should call Us as soon as possible.
• We will provide You with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

SECTION 15:

NMHPA - NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

What are the special rights for childbirth under NMHPA?

Policyholder health plans and health insurers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following an uncomplicated vaginal delivery, or less than 96 hours following an uncomplicated cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). **This Act does not change the benefit limits or Deductibles of the Plan.**

WOMEN'S HEALTH AND CANCER RIGHTS ACT - IMPORTANT MASTECTOMY NOTICE

What are the rights for reconstructive surgery after a mastectomy?

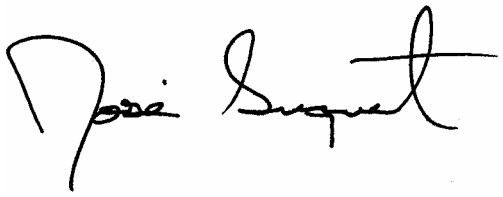
Effective October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act. The Act stipulates that any health plan that provides medical benefits for a mastectomy must also provide coverage for breast reconstruction if the Covered Person chooses to receive it. Specifically, any patient who is covered for mastectomy is also covered for reconstruction of the breast on which the mastectomy was performed, reconstruction of the other breast to achieve symmetry, and prostheses and physical complications of all stages of mastectomy including lymphedema. **This Act does not change the benefit limits or Deductibles of the Plan.**

Certificate of Insurance
under the
Group Named in the Summary of Benefits
For their Employees

Underwritten by
PAN-AMERICAN LIFE INSURANCE COMPANY
601 Poydras Street
New Orleans, Louisiana
TOLL FREE: [1-xxx-xxx-xxxx]

Pan-American Life Insurance Company has issued a Policy covering certain Employees of the Policyholder. The benefits of the Policy are described in this Certificate/booklet. Final interpretation is governed by the Policy. This Certificate/booklet replaces any and all Certificates previously issued for the Employees under the Plan. This Certificate/booklet describes the Policy in effect as of the Effective Date shown in the Summary of Benefits. This Certificate/booklet is the Employee's Certificate of Coverage only when the Employee is covered under the Policy.

PAN-AMERICAN LIFE INSURANCE COMPANY



Chairman of the Board
President and Chief Executive Officer

NOTICE CONCERNING YOUR PLAN

The benefits and provisions of the Plan are described in this Certificate. Additional benefits and provisions may apply based on the requirements of the state where the Policy is issued and the state where You live. These state benefits and provisions are described in separate amendments. See Policyholder for details.

TABLE OF CONTENTS

SECTION I: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

WHO IS AN ELIGIBLE EMPLOYEE?

Employees working at least an average of [30, 35 hours per week] will be eligible for coverage on the first day of the month following [30, 60, 90] days of employment.

TO BE ELIGIBLE TO ENROLL AS A COVERED PERSON, YOU MUST:

Be an Employee of the Policyholder.

TO BE ELIGIBLE TO ENROLL AS A DEPENDENT, YOU MUST BE:

1. Be the legal spouse of the Member; or

2. Be the natural child, step-child, or adopted child of the Member; or the child for whom the Member is the legal guardian, or the child who is the subject of a lawsuit for adoption by the Member, if the Member has the legal responsibility for the health of the child, or the child supported pursuant to a court order imposed on the Member (including a qualified medical child support order) or a grandchild of the Member who is also a Dependent of the Member for federal income tax purposes, provided that child:
    a. Is unmarried and legally dependent upon the Member for support;
    b. Has not reached age nineteen (19);
    c. Is age nineteen (19) but less than age twenty-five (25) and is a full-time student; or
    d. Is age nineteen (19) or older and is incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) years of age. You must submit proof of the child's condition and dependence to Us after the date the child ceases to qualify as a Dependent under section (b) above.

    A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

A. Enrollment during an Open Enrollment Period

If You meet the Employee or Dependent eligibility criteria, You may enroll as an Employee during the Open Enrollment Period by submitting a completed Enrollment Application, together with any applicable premium.

If enrolled during the Open Enrollment Period, the effective date of coverage will be the Plan Anniversary Date.

B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, You become eligible for coverage as a Member or a Dependent, You may enroll as a Member within thirty-one (31) days of the day on which You met the eligibility criteria. To enroll, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, Your effective date of coverage will be the day on which You meet the eligibility criteria.

2. If You are a Member who is enrolled for Employee coverage only, You may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. Newborn children of the Member are covered for the first thirty-one (31) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.

3. If You are a Member who is enrolled for Employee and family coverage, You may enroll a newborn child prior to the birth of the child or within ninety (90) days after the child's birth. Newborn children of the Member are covered for the first ninety (90) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.

4. If You are a Member who is enrolled for Employee coverage only, You may enroll an adopted child or child for whom You have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with You for adoption or within thirty-one (31) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

5. If You are a Member who is enrolled for Employee and family coverage, You may enroll an adopted child or child for whom You have been granted legal guardianship within sixty (60) days of the date the child is legally placed with You for adoption or within sixty (60) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

C. Special Open Enrollment Period

An eligible person and/or Dependent may also be able to enroll during a special Open Enrollment Period. A special Open Enrollment Period is not available to an eligible person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An eligible person and/or Dependent do not need to elect Cobra continuation coverage to preserve special enrollment rights. Special enrollments are available to an eligible person and/or Dependent even if Cobra is elected.

A special Open Enrollment Period applies to an eligible person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Acquiring a child as a result of being a party in a suit in which the adoption of the child by the Covered Person is sought.
- Placement for adoption.
- Marriage.

A special Open Enrollment Period applies for an eligible person and/or Dependent who did not enroll during the initial Open Enrollment Period or any applicable Open Enrollment Period if the following are true:

- The eligible person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the initial Open Enrollment Period or any applicable Open Enrollment Period; and

- Coverage under the prior plan ended because of any of the following:

  - Loss of eligibility (including, without limitation, legal separation, divorce or death).

  - The Policyholder stopped paying the contributions. This is true even if the eligible person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the Policyholder.

  - In the case of Cobra continuation coverage, the coverage ended.

  - The eligible person and/or Dependent no longer lives or works in a service area if no other benefit option is available.

  - The plan no longer offers benefits to a class of individuals that include the eligible person and/or Dependent.

  - An eligible person and/or Dependent incur a claim that would exceed a lifetime limit on all benefits.

D. Completion of Enrollment Application

Each Employee will need to complete the Enrollment Application. False, incomplete or intentional misrepresentation of a material fact provided in any Enrollment Application may cause the coverage of the Employee and/or his Dependent(s) to be null and void from its inception. A statement will not be used in a contest to void, cancel or non-renew Your coverage or to reduce benefits unless:

1. the statement is in a copy of the Enrollment Application; and
2. a signed copy of the Enrollment Application is or has been furnished to You or Your representative.

Coverage will only be contested because of fraud or intentional misrepresentation of a material fact on an Enrollment Application.

E. Hospitalization on the Effective Date of Coverage

If You are confined in a Hospital on the effective date of Your coverage; You must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter.

[F. Late Enrollee

A "Late Enrollee" is a person (including Yourself) for whom You do not elect coverage within 31 days of the date the person becomes eligible for such coverage.

An eligible Employee or Dependent will be required to provide proof of good health, at his cost, if he applies for coverage more than thirty-one (31) days after he becomes eligible or if he applies for reinstatement of coverage that was cancelled at his request.

Exceptions:

- A person will not be considered to be a Late Enrollee if all of the following are met:

  You did not elect coverage for the person involved within 31 days of the date You were first eligible (or during an open enrollment) because at that time the person was covered under other creditable coverage; and

- the person loses such coverage because:
  a. of termination of employment in a class eligible for such coverage;
  b. of reduction in hours of employment;
  c. Your spouse dies;
  d. You and Your spouse divorce or are legally separated;
  e. such coverage was COBRA continuation and such continuation was exhausted; or
  f. the other plan terminates due to the employer's failure to pay the premium or for any other reason; and

- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

If You are not considered a Late Enrollee, coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if You did not elect, when the person was first eligible, coverage for:

- A child who meets the definition of a Dependent, but You elect it later in compliance with a court order requiring You to provide such coverage for Your Dependent child. Such coverage will become effective on the date specified by the Policyholder. Any limitation as to a preexisting condition may apply.

- A spouse, but You elect it later and within 31 days of a court order requiring You to provide such coverage for Your Dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.

- Yourself and You subsequently acquire a Dependent, through marriage, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

- Yourself and You subsequently acquire a Dependent, through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

- Yourself and Your spouse and You subsequently acquire a Dependent through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself, Your spouse, and any such Dependent within 90 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

G. Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of Dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date Your coverage becomes effective; and
- You make written request for coverage for the child within 31 days (60 days if You already have Dependents covered) of the date the child is placed with You for adoption.

Coverage for the child will become effective on the date the child is placed with You for adoption. If request is not made within such 31 days (60 days if You already have Dependents covered), coverage for the child will be subject to all of the terms of this Plan.

H. Special Rules Which Apply to a Child Who Must Be Covered Due to a Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom You are required to provide health coverage as the result of a qualified medical child support order issued on or after the date Your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by the Policyholder.

If You are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

SECTION 2: DEFINITIONS

Throughout this Plan, you will find many terms in capital letters. These terms have special meaning in the Plan. When you find a term which has been capitalized, its meaning may be found in this section.

ACCIDENT
An unforeseen, unexpected and involuntary event which causes the Covered Person to suffer an Injury while covered under the Plan.

ACCIDENTAL BODILY INJURY/INJURY
Physical pain or impairment of a physical condition to a Covered Person that is:

A. Unforeseen;
B. Unexpected;
C. Involuntary; and
D. Due to violent and external means.

ALTERNATE FACILITY
A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services;
- Emergency Health Services;
- Urgent Care services;
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

APPLICATION
The form completed by the Policyholder in applying for coverage under the Policy.

CALENDAR YEAR
The period from January 1 through December 31 of the same year.

COMPLICATIONS OF PREGNANCY
Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible

Complications of pregnancy does not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy

CONVALESCENT FACILITY
An institution (or distinct part thereof) which meets fully every one of the following tests:

1. it is licensed to provide, and is engaged in providing on an inpatient basis, for persons convalescing from an injury or illness:
   - professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.), under the direction of a registered graduate nurse (R.N.);
   - Physician restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. its services are provided for compensation from its patients and under the fulltime supervision of a Physician or registered graduate nurse (R.N.);
3. it provides 24 hour per day nursing services by licensed nurses under the direction of a fulltime registered graduate nurse (R.N.);
4. it maintains a complete medical record on each patient;
5. it has an effective utilization review plan; and
6. it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders.

COVERED PERSON
A person who is eligible for coverage as an Employee or as a Dependent for whom premium is paid. A person who is eligible for coverage as an Employee or a Dependent according to the class(es) shown in the Policyholder's Application. No person may be covered as both an Employee and a Dependent at the same time. If Dependent coverage is elected, only one (1) person in the family may be covered as the Employee.

COVERED SERVICE(S)
Those health services provided for the purpose of preventing, diagnosing or treating a Sickness or Injury. A Covered Service is a health care service or supply described in "Section 3: Covered Services" as a Covered Service, which is not excluded under "Section 5: Exclusions".

CREDITABLE COVERAGE
Health care coverage under any of the types of plans listed below.

- a self-funded or self-insured Employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 et seq.);
- a group health benefit plan provided by a health insurance carrier or a health maintenance organization;
- an individual health insurance policy or evidence of coverage;
- Part A or Part B of Title XVIII of the Social Security Act (42 USC Section 1395c et seq.);
- Title XIX of the Social Security Act (42 USC Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 USC Section 1396s);
- Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.);
- a medical care program of the Indian Health Service or of a tribal organization;
- a state or political subdivision health benefits risk pool;
- a health plan offered under Chapter 89 of Title 5, United States Code (5 USC Section 8901 et seq.);
- a public health plan;
- a health benefit plan under Section 5(e) of the Peace Corps Act (22 USC Section 2504(e)); and
- short-term limited duration insurance;
- CHIP Program.

Creditable Coverage does not include:

- accident-only, disability income insurance, or a combination of accident-only and disability income insurance;
- coverage issued as a supplement to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit only insurance;
- coverage for onsite medical clinics;
- other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations;
- if offered separately, coverage that provides limited scope dental or vision benefits;
- if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits;
- if offered separately, coverage for other limited benefits specified by federal regulations;
- if offered as independent, noncoordinated benefits, coverage for specified disease or illness;
- if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; or
- Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 USC Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

DEDUCTIBLE/DEDUCTIBLE AMOUNT

The amount of money the Covered Person must pay for Eligible Expenses during each Calendar Year before the Plan begins to pay benefits.

DEPENDENT

A person who is:

1. The Employee's spouse;
2. Each unmarried child from birth to age 19 who is primarily dependent upon the Employee for support and maintenance;
3. Each unmarried child at least 19 years of age to age 25 who is primarily dependent upon the Employee for support and maintenance and who is a full-time student. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months; or
4. Each unmarried child at least 19 years of age:
   a) who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental or physical handicap;
   b) who was so incapacitated and is a Covered Person under this Policy on his or her 19th birthday; and
   c) who has been continuously so incapacitated since his or her 19th birthday.

If the dependent child is a full-time student and is a member of:

- the National Guard or any reserve component of the armed forces of the United States who are called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or
- the National Guard ordered to active State duty, including duty under 35 Pa.C.S. Ch. 76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days;

and is called to military duty, coverage under this Plan will not terminate if the dependent child reaches age 23 while on military duty, or after returning home, subject to the extension qualification requirements listed below.

Coverage under this Plan shall be extended for a period equal to the duration of the dependent's service on active duty or active State duty, or until the dependent is no longer a full-time student. In order to qualify for an extension, the dependent must:

1. Submit a form approved by the Department of Military and Veterans Affairs notifying Pan-American Life Insurance Company that the dependent has been placed on active duty.
2. Submit a form approved by the Department of Military and Veterans Affairs notifying Pan-American Life Insurance Company that the dependent is no longer on active duty.
3. Submit a form approved by the Department of Military and Veterans Affairs showing that the dependent has re-enrolled as a full-time student for the first term or semester starting 60 or more days after their release from active duty.

As used above, the term "full-time student" means a student enrolled in an approved institution of higher education pursuing an approved program of education equal to or greater than 12 credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study.

Children include:

- The Member’s biological children.
- The Member’s adopted children.
- The Member’s stepchildren.
- Any other child the Member supports who has a parent-child relationship with the Member.

If the Member has had the "Declaration of Domestic Partnership" completed and signed and the Declaration is acceptable to the Policyholder, the Member may also cover a person:

1. who is Your same sex "domestic partner"; and
2. who is named as such in Your Declaration.

No person may be covered both as an Employee and Dependent and no person may be covered as a Dependent of more than one Employee.

DOCTOR/PHYSICIAN

A person who is:

A. Licensed and recognized as a Provider of medical services by the State in which he practices; and
B. Recognized as a Provider of medical services by the insurance law of the State in which the Covered Person resides; and
C. Acts within the scope of his license; and
D. Gives treatment for which benefits are payable under the Plan, and
E. Other than for dental care covered under the Policy, Not one of the following:
    1. A person who ordinarily resides in the Covered Person's household; or
    2. A member of the Covered Person's immediate family.

DOMESTIC PARTNER

A person who is mentally competent to contract and either at least 18 years old, the age of majority or legally emancipated. In order to be eligible for Dependent coverage as a Domestic Partner, the person must not be sharing a permanent resident with another person who has obtained the age of majority, and must have the competency to consent to a contract for permanent residence. Evidence that the Domestic Partner and the Employee have shared a common residence and financial assets and obligations for an extended period of time must be provided to Us.

EFFECTIVE DATE

The date coverage under the Plan goes into effect for a Policyholder and his eligible Employees. It is shown in the Summary of Benefits of the Policyholder's Plan. An Employee's Effective Date of coverage is determined by the eligibility rules of the Plan and the payment of premium.

ELIGIBLE EXPENSE
Care, treatment, services, and supplies which must be:

1. Listed as an eligible Covered Service in the Plan; or authorized by the Utilization Management Company and approved by the Plan as an alternative form of treatment or facility; and
2. Medically Necessary for the care or treatment of an Injury or Illness; and
3. Recommended and approved by a Doctor.

An expense will not be an Eligible Expense to the extent that:

1. It is in excess of the Maximum Allowable Charge; or
2. The fee or charge would not have been made in the absence of medical coverage except for Medicaid and Tax Supported Institutions.

Expenses must be incurred after the person becomes covered under the Plan. We will determine the Eligible Expenses of the Plan. Charges in excess of the Maximum Allowable Charge will not be considered as Eligible Expenses.

EMERGENCY CARE.
Health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

1. placing the person's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of a bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMPLOYEE
An Employee of the Policyholder named in the Summary of Benefits, who qualifies for coverage according to an eligible class as described in the Application.

No person may be covered as both an Employee and a Dependent at the same time. If Dependent coverage is elected, only one (1) person in the family may be covered as an Employee.

ENROLLMENT FORM
The document completed by the Employee in electing coverage under the Policyholder's Plan.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES
Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If the insured has a life-threatening Illness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Service for that Illness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those identified by the National Institutes of Health.

HOME HEALTH CARE AGENCY

This is an agency that:

1. mainly provides skilled nursing and other therapeutic services; and
2. is associated with a professional group which makes policy; this group must have at least one physician and one R.N.; and
3. has full-time supervision by a physician or a R.N.; and
4. keeps complete medical records on each person; and
5. has a full-time administrator; and
6. meets licensing standards.

HOME HEALTH CARE PLAN

This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

1. prescribed in writing and reviewed at least every two month by the attending Physician; and
2. certified by the attending Physician as necessary for medical purposes and that the care and treatment is an alternative to confinement in a Hospital or convalescent facility.

HOSPICE CARE

Care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

HOSPICE CARE AGENCY

This is an agency or organization which has Hospice Care available 24 hours a day. It meets any licensing or certification standards set forth by the jurisdiction where it is, and provides:

1. skilled nursing services; and
2. medical social services; and
3. psychological and dietary counseling; and
4. bereavement counseling for the immediate family.

HOSPICE CARE PROGRAM

This is a written plan of Hospice Care, which is established by and reviewed from time to time by a Physician attending the person and appropriate personnel of a Hospice Care Agency. It is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families. This includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

HOSPICE FACILITY

This is a facility, or distinct part of one, which:

1. Mainly provides inpatient Hospice Care to terminally ill persons.
2. Charges its patients.
3. Meets any licensing or certification standards set forth by the jurisdiction where it is located.
4. Keeps a medical record on each patient.
5. Provides an ongoing quality assurance program; this includes reviews by Physicians other than those who own or direct the facility.
6. Is run by a staff of Physicians; at least one such Physician must be on call at all times.
7. Provides, 24 hours a day, nursing services under the direction of a R.N.
8. Has a full-time administrator.

HOSPITAL

An institution, operated as required by law, which is all of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

ILLNESS/SICKNESS
A. A disorder or disease of the mind or body; or
B. A pregnancy.

INDIVIDUAL/INDIVIDUALIZED TREATMENT PLAN
A treatment plan with specific attainable goals and objectives that are appropriate to:
A. the patient; and
B. the program's treatment modality.

INITIAL ENROLLMENT PERIOD
The initial period of time, as we agree with the Policyholder, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

INPATIENT REHABILITATION FACILITY
A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

MAXIMUM ALLOWABLE CHARGE
The amount determined by Us to be the appropriate fee. For services rendered by a Participating Provider, an amount not to exceed the Maximum Allowable Fee.

For all other charges, an amount not exceeding a charge routinely made by Providers in the locality where the charge is incurred for similar services or supplies. Consideration will be given to:
1. The Covered Person's condition; and
2. Unusual circumstances or complications; and
3. Requirements for additional time, skill or experience.

We will determine the Maximum Allowable Charge and if it is covered by the Plan.

MAXIMUM ALLOWABLE FEE
The amount agreed upon between a Participating Provider and the Plan (after any applicable Deductible) for Eligible Expenses for care, services, supplies and treatment or other medical care. If the Utilization Management Company negotiates an amount on a pre- or post-treatment basis for non-contracted Provider services, the charges will be the negotiated amount.

MEDICALLY NECESSARY
Any services or supplies provided for the diagnosis and treatment of a specific Illness, Injury, or condition which are:
A. Ordered or recommended by a Doctor; and
B. Required for the treatment or management of a medical condition or symptom; and
C. The most appropriate supply or level of service which can safely be provided to the Covered Person; and
D. Provided in accordance with approved and generally accepted medical or surgical practice; and
E. Not for the convenience of the Covered Person, his Doctor, or another Provider; and
F. Not for services or supplies which are experimental or investigational; and
G. Furnished in the least intensive type of medical care setting required by the Covered Person's condition.

Services and supplies will not automatically be considered Medically Necessary because they were ordered by a Doctor.

MENTAL ILLNESS
Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.

NETWORK
Care, services, supplies and treatment which are obtained through a Participating Provider.

NON-NETWORK
Care, services, supplies and treatment which are obtained through a Non-Participating Provider.

OPEN ENROLLMENT PERIOD
A period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. We and the Policyholder will agree upon the period of time that is the Open Enrollment Period.

OUTPATIENT REHABILITATION FACILITY
A facility (or a special unit of a Hospital) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an outpatient basis, as authorized by law.

PARTICIPATING PROVIDER
A participating Hospital, a Primary Care Physician (PCP), a specialist Physician, and any other licensed health care services Provider who has contracted with the Us to provide health care services to Covered Persons as Network benefits.

PARTICIPATING PROVIDER ORGANIZATION/PPO
An organization which establishes an arrangement between payers (Policyholders or insurers) and health care Providers. The Providers selected for participation in the PPO agree to be reimbursed at negotiated fees for their services.

PLAN
The benefit plan elected by the Policyholder which covers its Employees.

POLICYHOLDER
The [employer or plan sponsor] named in the Summary of Benefits as the Policyholder.

PRIMARY CARE DOCTOR/PHYSICIAN
A Physician who specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

PROVIDER
Any person or health care facility duly licensed or legally authorized to render care or services covered under the Plan.

REIMBURSEMENT PERCENTAGE
The percent of Eligible Expenses payable under the Plan and shown in the Summary of Benefits.

SKILLED NURSING FACILITY
A Hospital or nursing facility that is licensed and operated as required by law.

SPECIALIST CARE DOCTOR/PHYSICIAN
A Physician who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

TOTAL DISABILITY/TOTALLY DISABLED
With respect to primary insured covered under this Plan, the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability and with respect to any other individual person insured under this Plan, confinement as a bed patient in a Hospital.

URGENT CARE CLINIC
A facility, other than a Hospital, that provides Covered Services that are required to prevent serious deterioration of Your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

UTILIZATION MANAGEMENT COMPANY/UMC
A company or organization chosen by Us which meets the standards for utilization review established by the American Managed Care and Review Association and is certified or licensed to do business in the state as a utilization review agency, if applicable.

WAITING PERIOD
The time period an Employee must be employed by the Policyholder before becoming eligible for coverage under the Policy.

WE/US/OUR/COMPANY
Refers to Pan-American Life Insurance Company.

YOU/YOUR
The Employee who is covered under the Policyholder's Plan.

SECTION 3
SUMMARY OF BENEFITS/COVERED SERVICES

Calendar Year Deductible
Network: [$250, $500, $1,000, $2,000]
Non-Network: [$500, $1,000, $2,000, $4,000]
[2 Times, 2.5 Times, 3 Times, None] Calendar Year Family Deductible Limit

Overall Maximum per Calendar Year [(does not include Inpatient Facility Expenses)]
Inpatient & Outpatient: [$10,000, $25,000, $50,000, $75,000, $100,000] (combined for Network and Non-Network Coverage)
Outpatient Limited to: [$2,500, $5,000, $7,500, $10,000] (combined for Network and Non-Network Coverage)

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Hospital Inpatient Facility Expenses. This benefit pays for charges after the deductible for a total of 30 days each Calendar Year up to the following: [$2,000 per day for the first 4 days of Hospital confinement; and $1,000 per day for days 5 through 30]; [$250, $500, $1,000, $1,000, $2,000, $2,500, $3,000 per day].	$0	Yes	[100%, 85%, 80%, 75%]	[100%, 65%, 60%, 55%]
Physician Inpatient Services.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Outpatient Surgery, Diagnostic, and Therapeutic Services.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Primary Care Doctor's Office Visits (Non-Surgical).	[$15, $20, $25, $30] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Specialist Care Doctor's Office Visits (Non-Surgical).	[$30, $35, $40] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Urgent Care Clinic Visits (Non-Surgical).	[$35, $50] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Injections Received In A Doctor's Office. Benefits are available for injections received in a Doctor's office when no other health service is received.	[$15, $20, $25, $30] [Network Only] per visit	No (Network); [Yes] [No] (Non-Network)	100%	[85%, 80%, 75%, 65%, 60%, 55%]
Maternity Services. Benefits for Pregnancy will be paid at the same level as Covered Services for any other condition, Illness, or Injury. This includes all maternity related services for prenatal care, postnatal care, delivery, and any related complications. We will pay Covered Services for an Inpatient say of at least: 48 hours for the mother and newborn child following a normal vaginal delivery; 96 hours for the mother and newborn child following a cesarean section delivery.				
In Vitro Fertilization. Benefits for In Vitro Fertilization will be paid at the same level as Covered Services for any other condition, Illness, or Injury. Any pre-existing condition limitation shall not exceed a period of twelve (12) months. Lifetime maximum for In Vitro Fertilization: $15,000				
Hospice Care Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Home Health Care Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Spinal Disorder Treatment Expenses. Calendar Year maximum of 2 visits.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Routine Preventive Care*. This benefit has a combined (Network or Non-Network) Calendar Year maximum of [$150, $250, $500].	[$10, $15, $20, $25, $30] [Network Only] per visit.	No (Network); [Yes] [No] (Non-Network)	100%	[85%,80%, 75%, 65%, 60%, 55%]
Private Duty Nursing Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Prosthetic Devices Expenses. Calendar Year Maximum of $500.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Rehabilitation Services-Outpatient Therapy Calendar Year Maximum of $1,000.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Durable Medical Equipment Expenses. Calendar Year Maximum of $500.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Ambulance Services Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
Emergency Care Services. Services that are required to stabilize or initiate treatment in an Emergency. Emergency Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. [For Emergency Room Visits as the result of a Sickness, there is a [$250, $500, $1,000, None] (combined for Network or Non-Network Coverage) Calendar Year Maximum.]	$0	Yes	[85%, 80%, 75%] after the Deductible	

ADDITIONAL BENEFITS				
COVERED SERVICE	**CO-PAY AMOUNT**	**NEED TO MEET CALENDAR YEAR DEDUCTIBLE?**	**NETWORK COVERAGE**	**NON-NETWORK COVERAGE**
Reconstructive Surgery After Mastectomy Benefits will be payable on the same basis as any other similarly covered Inpatient Hospital Expense or Medical—Surgical Expense, as shown on the Summary of Benefits.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]
OTHER BENEFITS				
Other Medical Expenses.	$0	Yes	[85%, 80%, 75%]	[65%, 60%, 55%]

Pregnancy Coverage: Benefits are payable for pregnancy-related expenses of female Employees and dependents, including Complications of Pregnancy, on the same basis as any other illness.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following an uncomplicated vaginal delivery; and a minimum of 96 hours following an uncomplicated cesarean delivery. If, after consultation with the attending Physician, a person is discharged earlier, benefits will be payable in accordance with recognized medical standards for that care by a health care provider, a registered nurse or another other appropriate licensed health care provider. The post delivery care may be provided at the women's home (at her option), a health care provider's office, a health care facility or another appropriate location. Charges for such post-delivery home visits will be paid at 100% and will not be subject to any Calendar Year Deductible.
- Authorization of the first 48 hours of such confinement following an uncomplicated vaginal delivery or the first 96 hours of such confinement following an uncomplicated cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, Your Physician, or other health care provider may obtain such authorization by calling the number shown on Your ID Card.

Pregnancy-related expenses are not subject to any Preexisting Condition limitation.

PREEXISTING CONDITION PROVISION

A "preexisting condition" is an injury or disease for which a person:
received treatment or services; or
took prescribed drugs or medicines;

during the[90 days] immediately preceding the person's effective date of coverage (or, if the Plan requires You to serve a probationary period, the [90 days] immediately preceding the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Policy and Certificate, whichever applies, to determine a person's effective date of coverage.

For the first [365] days following such date, Covered Services do not include any expenses for treatment of a preexisting condition.

[With respect to a Late Enrollee, a preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment. For the first 18 months after a Late Enrollee's enrollment date, Covered Services do not include any expenses for treatment of a preexisting condition.]

Special Rules As To A Preexisting Condition:

If a person had creditable coverage, then the preexisting limitation period under this Plan will be reduced by the number of days of prior creditable coverage.

As used above: "continuous creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Members' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED

We will not treat genetic information as a preexisting condition in the absence of a diagnosis of the condition related to the information.

LIMITATIONS:

Not covered are charges for a service or supply furnished by a Participating Provider that exceeds the negotiated charge agreed to by Participating Providers.

Explanation of Some Important Plan Provisions

Network and Non-Network Coverage Year Deductible
This is the amount of Network and Non-Network care, and other health care Covered Services You pay each Calendar Year before benefits are paid.
Network and Non-Network Care Family Coverage Year Deductible Limit
This limit applies to all Covered Services incurred for Network, Non-Network Care, and other health care by the Employee or his/her covered dependents. After that limit is reached, the Employee and his/her covered dependents will be deemed to have met separate Network and Non-Network coverage year Deductibles. The Network and Non-Network Family Coverage Year Deductible Limit is shown in the Summary of Benefits.

COVERED SERVICES

1. HOSPITAL INPATIENT FACILITY EXPENSES

Benefits are available for supplies, room and board, and non-Physician services received during the inpatient stay. Included are charges for services (non-Physician) made in connection with room occupancy. Benefits for Physician services are described under the section titled Physician Inpatient Services.

2. PHYSICIAN INPATIENT SERVICES (SURGICAL AND NON-SURGICAL)

Covered Services include the following charges made by a Physician:

Inpatient surgical and non-surgical services as follows:

1. Surgical services are the services of the operating Physician in performing a surgical procedure. This includes: The usual and related preoperative care; the administering of an anesthetic; the usual and related postoperative care.
2. Surgical assistance services are the services of a Physician in giving needed technical assistance to the operating Physician during a surgical service for which a benefit is paid under this Plan. No benefit is paid if such assistance is routinely done as a service by an intern; a resident Physician; or a house officer of a Hospital.
3. Anesthesia services are the services of a Physician in administering an anesthetic when a surgical services benefit is paid under this Plan. No benefit is paid if the anesthetic is administered by the operating Physician or his or her assistant.
4. Non-surgical medical treatment given to a Covered Person while confined as an inpatient in a Hospital, treatment facility, Inpatient Rehabilitation Facility, Convalescent Facility, Skilled Nursing Facility, or Hospice Facility and for consultation services given to a Covered Person while confined as an inpatient in such facility. Consultation services must be asked for by the attending Physician. A "consultation" is an exam of the Covered Person, a review of his or her x-ray and lab exams, and a review of the Covered Person's medical history. It will include a written report by the consulting Physician if the attending Physician requests one.

   No benefits are paid for consultation services:
   a. If the consulting Physician performs surgery as a result of the consultation.
   b. For staff consultations required by a facility.

3. OUTPATIENT SURGERY, DIAGNOSTIC/THERAPEUTIC AND THERAPEUTIC SERVICES

A. OUTPATIENT SURGICAL SERVICES

This benefit pays for Covered Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Surgeries performed in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

B. OUTPATIENT DIAGNOSTIC SERVICES

When ordered by a Physician, this benefit pays for Covered Services received on an outpatient basis at a Hospital or Alternate Facility for lab and radiology/x-ray, mammograms, bone mass measurement services, pap test, prostate cancer examination and testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, benefits are described under the Doctor's Office Visits Services below. It does not include CT Scans, PET Scans, MRI's, or nuclear medicine.

C. OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES-CT SCANS, PET SCANS, MRI AND NUCLEAR MEDICINE

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Diagnostic Services performed for CT Scans, PET Scans, MRI's, and Nuclear Medicine in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

D. OUTPATIENT THERAPEUTIC TREATMENTS

This benefit includes Covered Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge required for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Doctor's Office, benefits are described under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

4. PRIMARY CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)

We will pay for Covered Services received in a Primary Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Primary Care Doctor specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

5. SPECIALIST CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)

We will pay for Covered Services received in a Specialist Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Specialist Care Doctor is a Doctor who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

6. URGENT CARE CLINIC VISITS (NON-SURGICAL)

We will pay for Covered Services received in an Urgent Care Clinic for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Urgent Care Clinic Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

An Urgent Care Clinic provides services at a facility, other than a Hospital, and provides Covered Services that are required to prevent serious deterioration of the Covered Person's health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

7. INJECTIONS RECEIVED IN A DOCTOR'S OFFICE

Benefits are paid under this benefit for injections received in a Physician's office when no other health service is received.

Childhood immunizations are paid under the Routine Preventive Care Expenses benefit.

8. MATERNITY SERVICES

Benefits for Pregnancy will be paid at the same level as Covered Services for any other condition, Illness, or Injury. This includes all maternity related services for prenatal care, postnatal care, delivery, and any related complications. We will pay Covered Services for an Inpatient say of at least: 48 hours for the mother and newborn child following a normal vaginal delivery; 96 hours for the mother and newborn child following a cesarean section delivery.

9. HOSPICE CARE EXPENSES

Charges made for the following furnished to a person for Hospice Care when given as a part of a Hospice Care Program are included as Covered Services.

Facility Expenses
The charges made in its own behalf by a:

1. Hospice Facility;
2. Hospital;
3. Convalescent Facility;

which are for:
Board and room and other services and supplies furnished to a person while a full-time inpatient for:

1. pain control; and
2. other acute and chronic symptom management.

Not included is services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses

- Charges made by a Hospice Care Agency for:
  1. Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day.
  2. Medical social services under the direction of a Physician. These include assessment of the person's:
     i. social, emotional, and medical needs; and
     ii. the home and family situation;
     iii. identification of the community resources which are available to the person; and
     iv. assisting the person to obtain those resources needed to meet the person's assessed needs.
  3. Psychological and dietary counseling.
  4. Consultation or case management services by a Physician.
  5. Physical and occupational therapy.
  6. Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
  7. Medical supplies.
  8. Drugs and medicines prescribed by a Physician.
- Charges made by the providers below, but only if the provider is not an Employee of a Hospice Care Agency; and such agency retains responsibility for the care of the person.
  1. A Physician for consultant or case management services.
  2. A physical or occupational therapist.
- Not included are charges made:
  1. For bereavement counseling.
  2. For funeral arrangements.
  3. For pastoral counseling.
  4. For financial or legal counseling. This includes estate planning and the drafting of a will.
  5. For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
  6. For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

10. HOME HEALTH CARE EXPENSES

Home health care expenses are Covered Services if:
1. the charge is made by a Home Health Care Agency; and
2. the care is given under a Home Health Care Plan; and
3. the care is given to a Covered Person in his or her home; and
4. the Covered Person is homebound.

Home health care expenses include charges for:
1. Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
2. Part-time or intermittent home health aide services for patient care when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
3. Physical, occupational, and speech therapy.
4. Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.

The following to the extent they would have been covered under this Plan if the Covered Person had been Hospital confined:
1. medical supplies;
2. drugs and medicines prescribed by a physician; and
3. lab services provided by or for a home health care agency.

Home health care expenses do not include charges incurred for:

1. Services or supplies that are not a part of the Home Health Care Plan.
2. Services of a person who usually lives with a Covered Person or who is a member of the Covered Person's spouse's family.
3. Services of a social worker.
4. Transportation.
5. Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
6. Services that are custodial care. However, if the Covered Person is a minor or an adult who is dependent upon others for custodial care, coverage will be provided during times when there is a family member or caregiver present in the home to meet the Covered Person's custodial care needs. Coverage for home health care expenses is not determined by the availability of providers to provide care or services. The absence of a provider to perform a custodial care service does not cause the service to become a covered medical expense.

11. SPINAL DISORDER TREATMENT BENEFIT

Covered Services include charges incurred for:

1. manipulative (adjustive) treatment; or
2. other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Maximum Visits per Coverage Year will be payable for all expenses incurred in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full time inpatient in a Hospital
- for treatment of scoliosis
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating Physician.

12. ROUTINE PREVENTIVE CARE EXPENSES

Covered Services include charges made by a Physician for preventive care exams performed on a Covered Person for a reason other than to diagnose or treat a suspected or identified injury or disease.

Included as a part of the exam are:

1. X-rays, lab, and other tests given in connection with the exam; and
2. materials for the administration of immunizations for infectious disease and testing for tuberculosis.

Covered expenses for routine preventive care provided under this benefit include, but are not limited to, those charges made for:

1. Physical exams.
2. Cytological screening.
3. Colon cancer examinations and laboratory tests for:
   a. Covered persons who are fifty (50) years of age or older;
   b. Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
   c. Covered persons experiencing the following symptoms of colorectal cancer as determined by a licensed physician:
   (1) Bleeding from the rectum or blood in the stool; or
   (2) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days;
4. Prostate specific antigen tests and digital rectal exams.

5. Bone mass density measurements.
6. Mammograms
   a. A baseline mammogram for a woman covered by such a policy who is thirty-five (35) to forty (40) years of age;
   b. A mammogram for a woman covered by such a policy who is forty (40) to forty-nine (49) years of age, inclusive, every one (1) to two (2) years based on the recommendation of the woman's physician;
   c. A mammogram each year for a woman covered by such a policy who is at least fifty (50) years of age;
   d. Upon recommendation of a woman's physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer; and
   e. Insurance coverage for screening mammograms will not prejudice coverage for diagnostic mammograms as recommended by the woman's physician.

   We will not pay for mammography's performed in an unaccredited facility.
7. Routine Pap Smears

   Covered Services include charges incurred for:
   a. one routine gynecological exam each Calendar Year; and
   b. an annual routine Pap smear.

Mammography means radiography of the breast.

Screening mammography is a radiological procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two (2) views of each breast and includes a physician's interpretation of the results of the procedure.

Not included under this benefit are any exams; or other preventive services and supplies; which are specifically covered elsewhere in this Plan. The most that will be paid for all covered routine preventive care expenses incurred by a Covered Person in a Calendar Year under this benefit is the Routine Preventive Care Maximum.

13. PRIVATE DUTY NURSING EXPENSES

The charges of a:
1. R.N;
2. L.P.N.; or
3. nursing agency;

for private duty nursing provided on an inpatient or outpatient basis are deemed Covered Services.

No other charges made by an R.N. or L.P.N. or a nursing agency for private duty nursing are covered.

Not included as private duty nursing is:
1. that part or all of any nursing care that We determine does not require the skills of an R.N.; or
2. any nursing care given while the Covered Person is an inpatient in a health care facility, that could safely and adequately be furnished by that facility's general nursing staff if it were fully staffed.

14. PROSTHETIC DEVICES

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Doctor. Except for items required by the Women's Health and Cancer Rights Act of 1998, benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Except for items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Non-Network benefits for prosthetic devices is limited to $500 per Calendar Year. This limit applies to the total amount that We will pay for the prosthetics, and does not include any copayment or annual deductible responsibility the insured may have. Once the benefit limit is met, no additional benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.

15. REHABILITATION SERVICES – OUTPATIENT THERAPY

Benefits covered under this provision include short-term outpatient rehabilitation services for:

- Physical Therapy.
- Occupational Therapy.
- Speech Therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Doctor.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the condition of the insured within two months of the start of treatment.

Please note: We will pay benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke, or a congenital anomaly.

16. DURABLE MEDICAL EQUIPMENT

Covered Services for Durable Medical Equipment must meet the following criteria:

- Ordered or provided by a Physician for outpatient use;
- Used for medical purposes;
- Not consumable or disposable;
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost effective piece of equipment.

Durable Medical Equipment also includes hearing aids for a covered child under the age of eighteen if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a Physician and an audiological evaluation medically appropriate to the age of the child.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

We provide benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years. We will decide if the equipment should be purchased or rented. To receive Network benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify.

17. AMBULANCE SERVICE EXPENSES

This Plan pays the charges made by a professional ambulance service for:

1. the necessary air; water; or ground; transport of a Covered Person from the place where he or she has sustained an injury or is stricken by a disease to the nearest Hospital where treatment is given; and
2. the necessary non-emergency transfer of a Covered Person via ground ambulance or medical van.

Not covered are any charges made to transfer the Covered Person:

1. if ambulance service is not required by the Covered Person's physical condition;
2. if the type of ambulance service provided is not appropriate for the Covered Person's physical condition; and
3. via any form of transportation other than a professional ambulance service.

18. EMERGENCY ROOM SERVICES

We will pay for Covered Services incurred for Emergency Care due to an Illness or Injury for services Medically Necessary that do not result in Hospital Confinement. Emergency room benefits for an Illness will be paid for a Covered Person but will not exceed the overall Calendar Year maximum shown in the Summary of Benefits.

ADDITIONAL BENEFITS

1. Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:
a. All stages of the reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Benefits will be payable on the same basis as any other similarly covered Inpatient Facility Expense or medical-surgical Expense, as shown on the Summary of Benefits.

Prohibitions: We may not (a) offer the Covered Person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any Covered Person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the Physician or provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or provider to provide care to a Covered Person in a manner inconsistent with the coverage and/or benefits shown above.

Other Medical Expenses

1. Covered Services include charges incurred by a Covered Person for equipment, supplies and outpatient self-management training and education for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

   Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthodics.

   Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician includes:
   a. visits medically necessary upon the diagnosis of diabetes;
   b. visits under circumstances whereby a Physician identifies or diagnoses a significant change in the Covered Person's symptoms or conditions that necessitates changes in a Covered Person's self-management; and
   c. visits where a new medication or therapeutic process relating to the Covered Person's treatment and/or management of diabetes has been identified as medically necessary by a Physician.

2. Formulas that are equivalent to a prescription drug necessary for the therapeutic treatment of rare hereditary genetic metabolic disorders. As used in this provision: Rare hereditary genetic metabolic disorders are phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

3. The following charges when incurred by a Dependent child are included as Covered Services even though not incurred in connection with the treatment of a disease or injury.

   Children's Preventive Health Care Services

   Physician-delivered or physician-supervised services for eligible dependents from birth through age eighteen (18) years of age, with Periodic Preventive Care Visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section.

   Periodic Preventive Care Visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice, provided at the following age intervals:

   A. Birth;
   B. Two (2) weeks;
   C. Two (2) months;
   D. Four (4) months;
   E. Six (6) months;
   F. Nine (9) months;
   G. Twelve (12) months;
   H. Fifteen (15) months;
   I. Eighteen (18) months
   J. Two (2) years;
   K. Three (3) years;
   L. Four (4) years;
   M. Five (5) years;
   N. Six (6) years;
   O. Eight (8) years;
   P. Ten (10) years;
   Q. Twelve (12) years;
   R. Fourteen (14) years;
   S. Sixteen (16) years; and
   T. Eighteen (18) years.

   Benefits for recommended immunization services are payable at 100% with no deductible, copayment, coinsurance or maximum limit.

4. Covered Services include charges incurred for outpatient In Vitro Fertilization expenses, even though not incurred for treatment of a disease or injury by a female employee or by the dependent wife of a male employee. Expenses incurred for cryo preservation are also included.

   Benefits are provided on the same basis as any other illness if all of the following tests are met:
   a. The procedures are performed while she is not confined in a hospital or any other facility as an inpatient.
   b. Her oocytes are fertilized with her husband's sperm.
   c. She and her husband have a history of infertility which has lasted at least 2 years or the infertility is associated with one or more of these conditions.
      1) Endometriosis;
      2) Exposure in utero to diethylstilbestrol; known as DES;
      3) Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy; or
      4) Abnormal male factors contributing to the infertility.
   d. She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
   e. The in vitro fertilization procedures are performed:
      1) at a medical facility licensed or certified by the Arkansas Department of Health; or
      2) certified by the Arkansas Department of Health as either:
         a) meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
         b) meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

   Not more than the In Vitro Fertilization Maximum will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

5. Covered Services include charges incurred the necessary care and treatment of loss or impairment of speech or hearing payable on the same basis as any other illness.

   Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

   Coverage is not provided for hearing instruments or devices.

6. Mastectomy or Lymph Node Dissection

   Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:
   a. 48 hours following a mastectomy; and
   b. 24 hours following a lymph node dissection.

   The minimum number of inpatient hours is not required if the Covered Person receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

   Prohibitions: We may not (a) deny any Covered Person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any Covered Person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Covered Person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management Program uses the services of a Utilization Management Company to determine whether Covered Services are Medically Necessary. It is the Covered Person's responsibility to read and understand this benefit. The Covered Person should ask the Policyholder about how this program works.

The Utilization Management Program requires the cooperation of the Covered Person, Doctors, Providers, and Us. This program consists of medical review, medical case management, and mental illness and substance abuse reviews.

All Participating Providers have agreed to participate in the Utilization Management Program. This does not relieve the Covered Person of his responsibility to comply with all of the requirements of the Utilization Management Program.

For Your assistance in contacting the Utilization Management Company , a toll-free number has been placed on Your I.D. Card.

Following the review, the Utilization Management Company will issue written documentation to the Provider and the Covered Person which specifies the conditions of the authorization. Any payments for Covered Services are subject to all the terms and conditions of the Plan.

The ultimate decision as to whether any care should be received is between the Covered Person and the Doctor. If the Covered Person chooses to enter the Hospital or receive treatment without obtaining pre-authorization. Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of benefits will be reduced by 50%.

The Utilization Management Company may suggest the use of alternate forms of treatment or facilities which are not covered under the Plan. When this occurs, subject to Our approval, these expenses will be covered under the Plan on the same basis as the care and treatment for which they are substituted.

MEDICAL REVIEW PROGRAM

All Hospital admissions are subject to pre-authorization by a Utilization Management Company (UMC) selected by Us, and it is the Covered Person's responsibility to comply with all of the requirements of this program unless the Covered Person receives covered services from a Network Provider in which case it is the Network Provider's responsibility to notify the Utilization Management Company (UMC) for certification of a Hospital admission.

The Doctor, the Covered Person, or a member of his family must notify this organization as follows:

- Prior to a non-emergency admission;
- Within 24 hours, or on the first business day following an emergency admission.

The Utilization Management Company will review the applicable information and authorize:

- The Hospital admission, if it is Medically Necessary;
- The appropriate initial length of stay;
- Any extension beyond the original length of stay if it is Medically Necessary;
- An alternative course of treatment.

If pre-authorization is obtained, Eligible Expenses will be paid the same as any other Illness.

If pre-authorization for Hospital admissions is not obtained as stated above, benefits will be reduced after the Deductible Amount has been satisfied. Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of Benefits will be reduced by 50%. Note, if the Network Provider fails to obtain certification from the Utilization Management Company, no penalty may be assessed the Covered Person.

MEDICAL CASE MANAGEMENT

Medical Case Management is intended to improve the effectiveness of health care by monitoring patient treatment plans and working directly with Doctors and patients to optimize care.

Medical Case Management is indicated only for patients who have diagnoses which typically require expensive or prolonged treatment, and which can frequently be optimized through a personal assessment. It takes physical, clinical, and psychosocial factors into consideration during the process.

Once a patient is determined to be a candidate for Medical Case Management, a case manager may perform any or all of the following:

1)Establish a working relationship with the patient's Doctors and other members of the health care team to assess the patient's needs;

2)Identify cost effective alternatives for treating the patient;

3)Develop a treatment plan that can maximize the patient's level of functioning.

SECTION 4: DESCRIPTION OF NETWORK AND NON-NETWORK BENEFITS

This section includes information about:

• Network Benefits.
• Non-Network Benefits.
• Emergency Care Services.

NETWORK BENEFITS

Network benefits are generally paid at a higher level than Non-Network benefits. Network benefits are payable for Covered Services which are either of the following:

- Provided by or under the direction of a Network Physician or other Network Provider in the Physician's office or at a Network facility.
- Emergency Care Services.

COMPARISON OF NETWORK AND NON-NETWORK BENEFITS

- Network benefits offer a higher level of benefits which means less cost to You. See the Summary of Benefits.

- Non-Network benefits offer a lower level of benefits which means more cost to You. See the Summary of Benefits.

WHO SHOULD FILE CLAIMS

Network

Not required. We pay Network Providers directly.

Non-Network

You must file claims. See Section: How to File a Claim.

PROVIDER NETWORK

Network Providers are independent practitioners. They are not Our Employees. It is Your responsibility to select Your Provider.

Before obtaining services You should always verify the Network status of a Provider. A Provider's status may change. You can verify the Provider's status by contacting customer service.

It is possible that You might not be able to obtain services from a particular Network Provider. The network of Providers is subject to change. Or You might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network benefits.

DESIGNATED FACILITIES AND OTHER PROVIDERS

A. If Your Physician is a Network Provider, the Network Provider will notify Us of situations that might warrant a move to a designated facility or Non-Network facility or Provider if:
   1. You have a medical condition requiring special service needs (including, but not limited to, transplants or cancer treatment); or
   2. You require certain complex Covered Services for which expertise is limited;

   Benefits will be paid at the Network level.

B. If your Physician is a Non-Network Provider, it is Your responsibility to make sure we are notified of the above situations. If We are not notified in advance and if You receive services from a Non-Network facility (regardless of whether it is a designated facility) or other Non-Network Provider, Eligible Expenses payable at the applicable Reimbursement Percentage shown in the Summary of Benefits for Non-Network Benefits will be reduced by 50%. Non-Network Benefits will be available if the special needs services You receive are Covered Services for which Benefits are provided under the Policy.

HEALTH SERVICES FROM NON-NETWORK PROVIDERS PAID AS NETWORK BENEFITS

If specific Covered Services are not available from a Network Provider, You may be eligible for Network Benefits when Covered Services are received from Non-Network Providers. In this situation, Your Network Physician will notify Us, and we will work with You and Your Network Physician to coordinate care through a Non-Network Provider. If we authorize care through the Non-Network Provider, benefits would be paid as if the services were received from a Network facility or provider.

CONTINUITY OF CARE

If You are under the care of a Network Provider for one of the medical conditions below, and the Network Provider caring for You is terminated from the Network by Us, we can arrange, at Your request and subject to the Provider's agreement, for continuation of Covered Services rendered by the terminated Provider as a Network Benefit.. Medical conditions and time periods for which treatment by a terminated Network Provider will be covered under the Plan as a Network Benefit are:

- A life-threatening illness. Treatment by the terminated Provider may continue as a Network Benefit until the course of treatment is complete, not to exceed three months from the effective date of termination.
- A high risk Pregnancy or a Pregnancy that is past the twenty-fourth week of Pregnancy. Treatment by the terminated Provider may continue as a Network Benefit until the postpartum services related to the delivery are complete. For the purposes of this section "life-threatening illness" means a severe, serious, or acute condition for which death is probable.

This section does not apply when:
- The reason for such termination is due to suspension, revocation, or applicable restriction of the health care Provider's license to practice in this state, or for another documented reason related to quality of care.
- You choose to change health care Providers.
- You move out of the geographic service area of the health care Provider.
- You require only routine monitoring for a chronic condition but is not in an acute phase of the condition.

NON-NETWORK BENEFITS

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Services which are either of the following:

- Provided by Non-Network Providers.
- Provided under the direction of a Non-Network Physician at a Non-Network facility or program.

PRE-AUTHORIZATION REQUIREMENT

You must obtain prior authorization from Us before getting certain Covered Services from Non-Network Providers. For more information please contact customer service

Prior authorization does not mean Benefits are payable in all cases. Coverage depends on the Covered Services that are actually given, Your eligibility status, and any benefit limitations.

NON-NETWORK EMERGENCY CARE SERVICES

Subject to the Deductible, we will provide Benefits for Emergency Care Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Care Services, even if the services are provided by a Non-Network Provider. Emergency Care services will be provided as a Network Benefit until the Insured can be reasonably be expected to be transferred to Network Provider. If You are confined in a Non-Network Hospital after You receive Emergency Care Services, we request notification within one business day or on the same day of admission if reasonably possible. No penalty will be assessed the Covered Person if notification is not given within these time frames if it is shown that it was not reasonably possible to do so. In any event, notification should be provided to Us as soon as is reasonably possible. We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date we decide a transfer is medically appropriate, Non-Network Benefits will be available if the continued stay is determined to be a Covered Service.

EMERGENCY CARE SERVICES includes a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is necessary to determine whether a medical emergency condition exists; necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and services originating in a Hospital emergency facility following treatment or stabilization of an emergency medical condition.

SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS

Services and supplies are not covered if they are:

1. not Medically Necessary;
2. in excess of the Maximum Allowable Charge;
3. not prescribed, recommended or approved by a Physician;
4. not furnished within the scope of the Physician's license;
5. furnished while the person is not a Covered Person by the Policy;
6. provided to the Covered Person or insurer with no legal obligation to pay;
7. furnished by a government plan or facility, unless the Covered Person is legally obligated to pay (except Medicaid and mental health benefits and mental retardation benefits provided by a tax supported institution);
8. for Custodial Care solely for personal needs, comfort or convenience of the Covered Person;
9. to control the Covered Person's environment;
10. provided by the immediate family;
11. provided mainly for education, training or vocational rehabilitation or counseling; or
12. not specifically included as a Covered Service or specifically excluded as not covered by the Plan.

Benefits are not provided for Expenses incurred from:

1. Injury or Sickness:
   a. arising out of or in connection with employment or occupation for wage or profit;
   b. covered or eligible for coverage under Workers' Compensation or any occupational disease, employer's liability or similar law,
   c. caused by an act of declared or undeclared war;
   d. occurring while on active duty with any military, naval or air force of any country or international organization, except this will not apply to orders for active service for training purposes of two month or less;

   e. resulting from the Covered Person's participation in an assault or felony, or while engaged in an illegal occupation;
   f. resulting from intentionally self-inflicted Injury, suicide or attempted suicide;
   g. resulting from voluntary taking of any gas or poison or voluntary taking of any drug, sedative, or narcotic unless prescribed by a Physician and taken according to the prescribed dosage;
   h. resulting from driving a motor vehicle while legally intoxicated according to the laws of the state where the Injury occurs;
   i. occurring while outside of the United States;

2. Procedures or devices that are:
   a. in a research or experimental stage;
   b. considered as experimental or investigational by the protocol of the U. S. Department of Health and Human Services or any of its agencies;
   c. not generally accepted as effective treatment by the U. S. medical community;
   d. primarily used in a laboratory or research setting that has progressed to only limited human use; or
   e. not of demonstrated value for the diagnosis and treatment of an Injury or Sickness;

3. Drugs and medicines that are:
   a. not prescribed by a Physician, or that are not approved by the U. S Food and Drug Administration;
   b. over-the-counter medications of any kind except for medications for the treatment of diabetes;
   c. nutritional supplements, minerals and vitamins, such as, but not limited to, pre-natal vitamins. This exclusion does not apply to formulas for the therapeutic treatment of rare hereditary genetic metabolic disorders;
   d. growth hormones;
   e. determined to be "less than effective" by the Drug Efficiary Study Implementation (DESI) Program;
   f. fertility agents;
   g. for cosmetic use including, but not limited to Retin-A for a Covered Person age 25 and over;
   h. anti-smoking aids, such as, but not limited to, Nicorette Gum;
   i. Dexadrine for a Covered Person over the age of 18;
   j. used to treat or cure baldness, such as, but not limited to, Rogaine or Monoxidil; or
   k. outpatient prescriptions;

4. Hospital admission from Friday 8:00 A.M. through Monday 12:01 A.M. unless surgery is performed within 24 hours of the admission, or because of an emergency;

5. Hospital Confinement that is not Medically Necessary and is solely for the convenience of the Covered Person or Physician;

6. Cosmetic surgery, which term includes but is not limited to:
   a. surgery to the upper and lower eyelid;
   b. augmentation mammoplasty;
   c. full or partial facial lifts;
   d. dermal or chemo abrasion;
   e. scar revision;
   f. otoplasty;
   g. lift, stretch or reduction of abdomen, buttocks, thighs or upper arm;
   h. silicone injections to any part of the body; and
   i. rhinoplasty;

   unless such surgery is required for a condition resulting from congenital defects or birth abnormalities of a newborn child or from Injury, and (except for a newborn child) such Injury occurred while the Covered Person was insured under the Plan;

7. Dental services or supplies, except for the following procedures:
   a. to repair damage to sound natural teeth Accidentally injured while the person is a Covered Person and the repair is done within 12 months from the date of the Injury;
   b. to remove impacted, unerupted teeth;
   c. Reconstructive Surgery for Craniofacial Abnormalities for dependent children under age 18; and
   d. Anesthesia and dental care in a hospital or ambulatory surgical center for a covered person for which the provider treating the patient certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and who:
      (1) is a child under age seven who is determined by two licensed dentists, to require without delay necessary dental treatment for a significantly complex dental condition; or
      (2) is a person with a diagnosed serious mental or physical condition; or
      (3) is a person with a significant behavioral problem as determined by the Covered Person's physician.

8. Eye exams, testing for refraction, eye or visual exercises, vision therapy, or contact lenses or eyeglasses;

9. Radial keratotomy or other surgery to correct or change refractive defects of the eye;

10. Injury resulting from travel, flight in, or descent from any aircraft owned or leased by the Covered Person, or being in any aircraft being used for one or more of the following:
    a. test or experimental purposes;
    b. speed test;
    c. exhibition or stunt flying;
    d. crop dusting or seeding;
    e. hunting, herding or herd thinning; or
    f. fire fighting;

11. Injury while riding in or on a motorized vehicle of any type designed for or primarily used for racing, speed tests, or hazardous exhibition purposes;

12. Injury while engaging in any of the following hazardous activities:
    a. hang gliding or flying an ultra light aircraft;
    b. skydiving; or
    c. scuba diving;

13. Services or supplies for:
    a. diagnosis and testing of fertility or infertility other than In Vitro Fertilization;
    b. reversal of sterilization procedure; or
    c. artificial insemination;

14. Transsexual surgery or other sex modification procedures and any related complications;

15. Marriage counseling and any therapy or counseling for sexual dysfunctions;

16. Weight loss treatment or supplies of any kind, including but not limited to:
    a. gastric bypass, gastroplasty, or gastric stapling, regardless of Physician's recommendation for medical necessity;
    b. balloon catheterization;
    c. diet or exercise programs;
    d. weight reduction programs or clinics; or
    e. liposuction or reconstructive surgery other than reconstructive surgery for Mastectomy and Craniofacial Abnormalities;

17. Exercise equipment or programs regardless of their purpose;

18. Purchase of home based artificial kidney equipment;

19. Treatment or supplies of any kind for routine foot care for (except with respect to diabetic care):
    a. paring or removal of corns, calluses or toenails;
    b. instability or imbalance of the feet; or
    c. orthopedic shoes, orthoses and other supportive devices for the feet, except if needed for conditions resulting from diabetes;

20. Acupuncture, acupressure or massage therapy;

21. Charges for failure to keep an appointment, or to complete claims forms;

22. Hospital confinement for physical therapy, rehabilitation, diagnostic x-ray and laboratory services or other diagnostic studies, except when such care or services cannot be rendered on an outpatient basis;

23. Charges for biofeedback services;

24. Charges for any maintenance type therapy not reasonably expected to improve the patient's condition;

25. Charges for:
    a. any service or supply in connection with an organ transplant, except a human to human organ transplant;
    b. any transplant which is sold rather than donated to the Covered Person; or
    c. any service or supply in connection with autologous bone marrow transplantation for treatment of any disease other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, and neuroblastomas;

26. Treatment, services or supplies for any of the following except if described as a Covered Service by the Policy:
    a. Home Health Care;
    b. abortion unless the life of the mother would be threatened if the fetus were carried to term;
    c. pre-employment or pre-marital examinations;
    d. in vitro, in ovum fertilization or Gamete Intrafallopian Transfer (GIFT);
    e. hearing aids, implants, their fitting, and related hearing tests and exams.

27. Breast reductions are excluded regardless of the Physician's recommendation of Medical Necessity except in connection with Breast Reconstructive Surgery after a covered mastectomy; or

28. In connection with a Genetic Test or chromosome analysis.

29. Charges for a Pre-Existing Condition, except as provided in the Covered Services section of the Plan.

30. Osteotomies, chelation therapy and orthomolecular medicine.

SECTION 6: TERMINATION OF COVERAGE

Termination of the Policy: The Policyholder may terminate the Policy by providing written notice to Us at least 30 days prior to termination. We may terminate the Plan on any date if:

1. The Policyholder fails to pay the premiums as required by the terms of the Plan;
2. The Policyholder has committed fraud or intentional misrepresentation of a material fact;
3. On the first renewal date following the end of a six month consecutive period during which the qualifying minimum participation requirement was not met; or;
4. The Policyholder fails to meet the required contribution requirements.

Termination of Covered Persons:

For the Employee, insurance terminates on the earliest of the following:

1. The date the Plan terminates;
2. The date any benefit of the Plan terminates, in regard to that benefit;
3. The date the Employee cancels insurance;
4. The date the Policyholder cancels insurance for the Employee. The Policyholder must give advanced written notice at least 31 days prior to the date the insurance ends;
5. The date premiums are not paid when due, subject to the Grace Period provision;
6. The date the Employee's employment is terminated;
7. The date the Employee enters full-time military service. For purposes of this insurance, active military service for training purposes of two months or less is not full-time service; or
8. The date the Employee commits fraud upon Us or intentionally misrepresents a material fact which affects his coverage under the Plan.

For the insured **Dependent**, insurance terminates of the earliest of the following:

1. The date the Employee's coverage terminates;
2. The date any benefit of the Plan terminates for the insured Dependent, in regard to that benefit;
3. The date the Employee cancels the insured Dependent's insurance;
4. The date the Policyholder cancels insurance for dependents. The Policyholder must give advanced written notice at least 31 days prior to the date the insurance ends;
5. The date premiums are not paid when due for the insured Dependent, subject to the Grace Period provision;
6. The date the insured Dependent no longer meets the definition of Dependent except that coverage for a grandchild will not terminate solely because grandchild is no longer a Dependent of the Employee for federal income tax purposes.
7. With respect to the Employee's spouse, the date the Employee is divorced from such spouse;
8. The date the insured Dependent commits fraud upon Us or misrepresents a material fact which affects his coverage under the Plan; or
9. The date the insured Dependent enters full-time military service. For purposes of this insurance, active military service for training purposes of two months or less is not full-time service.

Notwithstanding the above, in the event a Covered Person ceases to be eligible for coverage, and the Policyholder fails to report to Us the termination of coverage of the person at least 30 days prior to the pending termination date, coverage will continue for the Covered Person until the end of the month in the Policyholder notifies Us that the Coverage Person is no longer eligible for coverage. The Policyholder will be liable for all premiums for such coverage.

LIMITED EXTENSION DUE TO TOTAL DISABILITY

A Covered Person's benefits will continue to be payable under the Plan when the Policy terminates, if he;

A. Is Totally Disabled; and
B. Is confined to a Hospital for the disabling Illness or Injury at the date the Policy would otherwise terminate.

Benefits paid under this extension will be paid until the earliest of these dates:

A. The date which is ninety (90) days from the date coverage would have otherwise terminated; or
B. The date the Covered Person is no longer Hospital confined; or
C. The date on which the disabled person's Medical Benefit has reached the applicable maximum under the Plan.

This extension of coverage applies only to the disabled person and no premium is due.

SECTION 7: COORDINATION OF BENEFITS

This section applies if You are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If You are covered by more than one health benefit plan, You should file all claims with each plan.

A. Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

Plan
Any of the following that provides benefits or services for medical care or treatment with which coordination is allowed:

1. Group insurance and group subscriber contracts;
2. uninsured arrangements of group or group-type coverage;
3. group or group-type coverage through HMOs and other prepayment, group practice, and individual practice plans;
4. group-type contracts which are contracts that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.
5. the amount by which group or group-type hospital indemnity benefits exceed $100 per day;
6. the Medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and
7. Medicare or other governmental benefits, except a state plan under Medicaid. That part of the definition of "plan" may be limited to the hospital, medical, and surgical benefits of the governmental program.

Each type of coverage You have in the above categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefits rules, each of the parts shall be treated as a separate Plan.

Plan does not include any of the following:
1. individual or family insurance contracts;
2. individual or family subscriber contracts;
3. individual or family coverage through health maintenance organizations (HMOs);
4. individual or family coverage under other prepayment, group practice, and individual practice plans;
5. group or group-type hospital indemnity benefits of $100 per day or less;
6. school accident-type coverages which cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; and
7. a state plan under Medicaid;
8. plans when, by law, their benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Primary Plan.

A plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A plan is a "primary plan" if either of the following conditions is true:
1. the plan either has no order of benefit determination rules, or
2. it has rules which differ from those permitted by this subchapter.

There may be more than one "primary plan"; or all plans which cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan

A plan which is not a "primary plan." If a person is covered by more than one "secondary plan," the order of benefit determination rules of these sections decide the order in which their benefits are determined in relation to each other. The benefits of each "secondary plan" may take into consideration the benefits of the "primary plan" or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that "secondary plan.

Allowable Expense

The necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

Examples of expenses or services that are not an Allowable Expense include, but are not limited to the following:

1. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
2. The difference between the cost of a private Hospital room and the cost of a semi-private hospital room is not considered an "allowable expense" under this section unless the covered person's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.
3. If You are covered by two or more Plans that provide services or supplies on the basis of usual and customary fees, any amount in excess of the highest usual and customary fee is not an Allowable Expense.
4. When benefits are reduced under a primary plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an "allowable expense." Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.
5. When a plan provides benefits in the form of service, the Reasonable Cash Value of each service will be considered as both an "allowable expense" and a benefit paid.

Claim Determination Period

A calendar year, but it does not include any part of a year during which You are not covered under this Agreement or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed Provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care Providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

B. Order of Benefit Determination Rules

A primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. A secondary plan may take the benefits of another plan into account only when, under this subchapter, it is secondary to that other plan.

In determining the order of benefit, the first of the following rules will applies.

1. The benefits of the plan which covers the person as an Employee, member, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent. There is one exception. If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired Employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.
2. With respect to a dependent child whose parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. As used in this paragraph, the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born. If the plan does not have the rule based upon the parent's birthday, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon gender of the parent will determine the order of benefits.

3. With respect to a dependent child whose parents are separated or divorced, where two or more plans cover the child, benefits for the child are determined in this order:
   a. first, the Plan of the parent with custody of the child;
   b. Then, the Plan of the spouse of the parent with the custody of the child; and
   c. finally, the Plan of the parent not having custody of the child.

   d. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
   e. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (2) of this subsection.
4. With respect to active as related to inactive Employees, the benefits shall be determined in the following order. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's dependent) are determined before those of a plan which covers that person as a laid off or retired Employee (or as that Employee's dependent). If the other Plan does not have this rule; and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. With respect to continuation coverage, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
   a. first, the benefits of a plan covering the person as an Employee, member, or subscriber (or as that person's dependent);
   b. second, the benefits under the continuation coverage.
   c. If the other plan does not have the rule described in subparagraphs a. and b. of this paragraph, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
6. Where none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term.
   a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
   b. The start of a new plan does not include:
      (i) a change in the amount or scope of a plan's benefits;
      (ii) a change in the entity which pays, provides, or administers the plan's benefits; or
      (iii) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
   c. The person's length of time covered under a Plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a member of the group will be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

C. Effect on the Benefits of this Agreement

If we are the Secondary Plan, we may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses.

The difference between the benefits payments that we would have paid had we been the Primary Plan and the benefit payments that we actually paid as the Secondary Plan shall be recorded as a benefit reserve for You. We will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

If there is a benefit reserve, we shall use the benefit reserve recorded for You to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, Your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination.

D. Recovery of Excess Benefits

If we provide Services and Supplies that should have been paid by the primary Plan or if we provide services in excess of those for which we are obligated to provide under this Agreement, we shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We shall have the sole discretion to seek such recovery from any person to, or from whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If we request, You shall execute and deliver to such instruments and documents as we determine are necessary to secure its rights.

E. Right to Receive and Release Information

We, without consent of or notice to You, may obtain information from and release information to any Plan with respect to You in order to coordinate Your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate Your benefits pursuant to this section.

SECTION 8:
THIS PROVISION IS SUBJECT TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) AND ALL SUBSEQUENT LAWS EFFECTING THIS ACT.

This provision applies to a Policyholder with twenty (20) or more Employees on a typical business day during the preceding Calendar Year if group health coverage was provided to Employees.

Introduction

You are receiving this notice because You have recently become covered under a group health plan (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Plan and under Federal Law, You should review the Policy or Certificate of Coverage or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualifying beneficiary". You, Your spouse, and Your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
-

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "Dependent child".

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Policyholder must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or a Dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of an Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability extension of 18 month period of continuation coverage

If Your or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage.

Second qualifying event extension of 18 month period of continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare (under Part A, Part B, or both), or gets divorced or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

SECTION 9: CONTINUATION OF COVERAGE

As an alternative to continuation of coverage under COBRA, the following continuation provisions are available to the following Covered Persons:

- Employees whose coverage ends for any reason other than termination of this policy or termination of the class in which the employee was insured.
- The surviving spouse or divorced spouse of an employee whose coverage would otherwise terminate as a result of the divorce or the death of the employee.

Continuation is not available to:

- Employees whose coverage ends because of failure to pay any required contribution towards the cost of their coverage under the policy.
- Covered Persons who are eligible for Medicare.
- Covered Persons whose coverage is replaced by another group medical plan within 31 days after coverage under this policy terminates.
- Covered Persons who have not been insured for at least three months on the date their coverage under this policy ends.

Continuation of coverage is subject to payment of premium to the Policyholder by the Covered Person. The premium will be the amount of premium the Policyholder would pay for the coverage if the Covered Person was insured under this policy in the absence of this continuation provision, including amounts paid towards premium by the Policyholder and by the employee.

Coverage under this policy may be continued for up to 120 days after the month in which coverage under this policy would otherwise terminate except:

- Covered Persons whose coverage would end as a result of the divorce or death of the employee may continue coverage for up to 15 months after the end of the month in which coverage under this policy would otherwise terminate. Such continuation is subject to the Covered Person paying premium to the Policyholder in advance in three month increments.
- Covered Persons who are pregnant when coverage under this policy would otherwise terminate may continue coverage subject to the Covered Person paying premium to the Policyholder in advance in three month increments. Coverage may be continued for up to six months after the pregnancy ends, or if longer, the end of the second three month period following the three month period in which the pregnancy ends.

A Covered Person is eligible for Conversion at the end of this continuation period.

SECTION 10 – CONVERSION

Any Employee whose insurance under this Policy has been terminated for any reason, including discontinuance of this Policy in its entirety or discontinuance of an insured class will be entitled to have issued by Us an individual policy of health insurance (hereafter referred to as the "converted policy"). This provision only applies to individuals whose coverage terminates at the end of any COBRA or state continuation provision provided in the Policy. The converted policy may provide levels which are substantially similar to those provide under this Policy.

A Employee will not be entitled to have a converted policy issued if termination of the insurance under this Policy occurred for any of the following reasons:

a. the Employee failed to pay any required contribution;

b. any discontinued group coverage was immediately replaced by similar group coverage unless such person was declined coverage under the replacing group coverage; or

c. The person is, or could be, covered for Medicare benefits or similar benefits provided by any state or federal law, similar benefits provided on a group or individual basis or any benefits provided above which, together with the benefits provided under the conversion policy, would result in over-insurance.

Written application for the converted policy must be made and the first premium paid to Us not later than thirty-one (31) days after such termination. The converted policy will be issued without evidence of insurability.

The effective date of the converted policy will be the day following the termination of insurance under this Policy. The converted policy will cover the Employee and any dependents who were covered by this Policy on the date of termination of insurance.

This conversion privilege may be exercised at the Employee’s option at the end of any COBRA or state continuation of coverage provision provided under the group policy and will be available to the following:

1. the surviving spouse, if any, of the Employee with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or

2. the spouse of the Employee with respect to the spouse and children whose coverage terminates because the spouse ceases to be a qualified family member and while the Employee remains insured under the group policy, or

3. a child solely upon termination of the coverage by reason of ceasing to be a qualified family member under the group policy, or

4. the former spouse whose coverage under the group policy terminates by reason of an entry of a valid decree of divorce between the insured and spouse.

SECTION 11: GENERAL PROVISIONS

CALCULATION OF PREMIUM

On the Plan's Effective Date, the monthly premium for coverage on Employees and, if applicable, Dependents will be based on the rates shown on the Policyholder's Application for Insurance under the Plan.

We will have the right to change the premium rates or the basis on which premiums are calculated:

A. On any Plan Anniversary; or
B. On any premium due date; but not before the first Policy Anniversary and not more than once every six (6) months after the first Policy Anniversary.

We will provide written notice of any rate increase to the Policyholder at least sixty (60) days before the date the rate increase is to take effect. The rate then being charged must have been approved by Us. Any time period in which a rate must stay in effect will be shown in the Policyholder's Application.

HOW PREMIUMS ARE PAYABLE

Premiums must be paid in advance to Us at the Home Office in New Orleans, Louisiana. Premiums may also be paid to Our authorized agent in exchange for Our receipt signed by Our Officer and countersigned by the agent as evidence of such payment. Premiums may be paid as indicated on the Application. Upon written request to Us, the mode of premium payments may be changed on any Plan Anniversary with proper adjustments. The payment of any premium will not continue the Plan in force beyond the date the next premium is due, except for Grace Period provision.

GRACE PERIOD FOR PAYMENT OF PREMIUMS

If the Policyholder has not given written notice to Us to cancel the Plan, a Grace Period of at least thirty-one (31) days will be allowed after the due date for the payment of each premium after the first. The Plan will continue in force during this period. If the premium is not paid before the end of the Grace Period the Plan will cease on the last day of the Grace Period. All valid claims will be paid for a loss incurred before the expiration of the Grace Period. A pro-rata premium will be due for the Grace Period.

If, before the end of the Grace Period, the Policyholder gives written notice to Us at Our Home Office that the Plan is to be cancelled, the Plan will terminate on the effective date of such notice. A pro-rata premium will be paid for the period between the date the premium was due and the date the Plan ends.

ASSIGNMENT

The coverage provided hereunder is assignable.

CANCELLATION

All or any part of the coverage provided under the Plan may be cancelled by the Policyholder by mailing to Us written notice at least thirty-one (31) days prior to the cancellation date. If the Policyholder cancels this plan, the coverage will end at 12:00 midnight on the last day of the policy month following the required notice period.

Delivery of written notice by either the Policyholder or Us shall be equivalent of mailing.

CONFORMITY WITH STATE STATUTES

Any provision of the Plan which, on its Effective Date, is in conflict with the statutes of the state in which the Plan was issued is hereby amended to conform to the minimum requirements of such statutes, unless otherwise forbidden by the laws of the state where the Covered Person lives.

INADVERTENT ERROR

The Covered Person will not lose the amount of coverage due to him because of error or failure by the Policyholder:

A. To give the name of a Covered Person who has qualified and made the proper payment for coverage; or
B. To report a change in the amount of coverage shown in the Policy or Certificate.

In the event of the Policyholder fails to report the termination of coverage of any Covered Person, the Policyholder will be liable for a Covered Person's premium from the time the Covered Person is no longer part of the group eligible for coverage until the end of the month in which the Policyholder notifies Us that the Coverage Person is no longer eligible for coverage.

INCONTESTABILITY OF PLAN

We will not contest the Plan after it has been in force for two (2) years, except:
A. For nonpayment of premium; or
B. For fraudulent misstatements or intentional misrepresentation of a material fact by the Policyholder.

No statement made by a Covered Person relating to his insurability will be used to contest his coverage:
A. After his coverage has been in force during his lifetime for two (2) years prior to the contest; and
B. Unless such statement is in writing and signed by him.

LEGAL ACTIONS

No legal action will be brought to recover under the Plan:

A. Until sixty (60) days have elapsed after proof of claim has been filed; or
B. After three (3) years from the end of the time within which proof of claim is required by the Plan.

MODIFICATION CAN BE MADE ONLY BY AN OFFICIAL

Only Our President, Vice-President, the Secretary or an Assistant Secretary can change or waive any provision of the Plan. Any changes must be made in writing. We will not be bound by any promises or representations made by an agent or anyone other than the above.

PLAN AND APPLICATION CONSTITUTE ENTIRE CONTRACT

The Plan, Application of the Policyholder for coverage under the Plan, and the Employee's' Enrollment Forms form the entire contract between the parties. All statements made by the Policyholder or by the Employee will be deemed representations and not warranties. No statement made by the Policyholder, the Employee, or his Dependent will be used in any contest unless a copy of the instrument containing such statement is or has been furnished to the Employee.

PRONOUNS

Masculine pronouns used in the Plan will apply to both sexes.

RECORDS OF THE POLICYHOLDER

The Policyholder will give such data as may be required by Us to provide the coverage. This includes data on Covered Persons becoming covered, changes in the amount of coverage and terminations of coverage. Payroll and other personnel records pertaining to coverage under the Policyholder's Plan will be open for review by Us at any reasonable time. Any additional records of the Policyholder as may have a bearing on the coverage shall also be open for review by Us at any reasonable time. The Covered Person will not lose the amount of coverage due him because of error or failure by the Policyholder:

A. To give the name of a Covered Person who has qualified and made the proper payment for coverage; or
B. To report a change in the amount of coverage shown in the Policy or Certificate.

Failure to report the termination of coverage of any Covered Person will not continue the coverage beyond the date of termination shown in the Policyholder's Plan.

WORKER'S COMPENSATION

The Plan is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.

RIGHT OF SUBROGATION

Subrogation means We have the right to request a refund of payments made by Us under the following conditions:

We will be subrogated to any claim a Covered Person has against a third party provided:

A. The Covered Person was injured or became ill due to the act or omission of the third party, and
B. We paid benefits to the Covered Person under the Plan for such Injury or Illness.

If the Covered Person collects any sums for damages from the third party, the Covered Person will be liable to Us for the benefits We paid. If the Covered Person sues to recover his expenses from a third party, We can join in the suit. If the Covered Person does not sue, We can do so in the name of the Covered Person.

The Covered Person is obligated to:

A. Avoid doing anything that would prejudice Our right of subrogation; and
B. Execute any documents reasonably required to enforce Our right.(Failure to execute the required documents does not waive our rights to collect any sums for damages from the third party.)

SECTION 12: UNIFORM CLAIMS PROVISION

NOTICE OF CLAIM

Written notice of claim must be given to Us within twenty (20) days after the date any Injury or Illness occurs or begins. If notice is not furnished within the time limit stated above, a claim will still be considered for payment and will not be denied or reduced due to the delay if it is shown that notice was given as soon as was reasonably possible.

CLAIM FORMS

We will furnish forms for filing proof of claim after We get the notice of claim. If such forms are not furnished within fifteen (15) days of receipt of the notice, the claimant will be deemed to have met with the terms of this provision of the Plan if he submits written proof of claim within the time set forth in the Proof of Claim provision.

PROOF OF CLAIM

Written proof of claim must be given to Us within ninety (90) days after the date of treatment.

However, the claim will not be denied or reduced if:

1. It is not reasonably possible to give proof in that time; and
2. Proof is submitted within one (1) year from the date of Loss or treatment.

This one (1) year period will not apply when the Covered Person is legally incapable of submitting proof. All proofs of claim must be satisfactory to Us.

TIME PAYMENT OF CLAIMS

Benefits payable under the Plan will be paid immediately after receipt of due written proof of claim. If all essential information needed to make a determination on the claim is not received, then the thirty (60) days will not be effective until all required information is received by Us.

PHYSICAL EXAMINATION

We, at Our own expense, will have the right to have a Covered Person examined as often as We may reasonably require, while a claim is pending.

How to File a Claim

This section provides You with information about:
• How and when to file a claim.
• If You receive Covered Services from a Network Provider, You do not have to file a claim. We pay these Providers directly.
• If You receive Covered Services from a Non-Network Provider, You are responsible for filing a claim.

If You Receive Covered Services from a Network Provider

We pay Network Providers directly for Your Covered Services. If a Network Provider bills You for any Covered Health Service, contact Us. However, You are responsible for meeting the Deductible.

If You Receive Covered Services from a Non-Network Provider

When You receive Covered Services from a Non-Network Provider, You are responsible for requesting payment from Us. You must file the claim in a format that contains all of the information we require, as described below.

You must submit a request for payment of Benefits within 90 days after the date of service. If You don't provide this information to Us within one year of the date of service, Benefits for that health service will be denied or reduced, according to the terms of the policy. This time limit does not apply if You are legally incapacitated. If Your claim relates to an inpatient stay, You must request payment of Benefits within 90 days of the date you are released from the Hospital.

We will pay benefits directly to a Physician or other health care provider, and will be relieved of the obligation to pay, and of any liability for paying, those benefits to the Covered Person if:
(1) the Covered Person makes a written assignment of those benefits payable to the Physician or other health care provider; and
(2) the assignment is obtained by or delivered to Us with the claim for benefits.

Required Information

When You request payment of Benefits from Us, You must provide Us with all of the following information:
A. The Covered Person's name and address.
B. The patient's name and age.
C. The number stated on Your ID card.
D. The name and address of the Provider of the service(s).
E. A diagnosis from the Physician.
F. An itemized bill from Your Provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
G. The date the Injury or Sickness began.
H. A statement indicating either that You are, or You are not, enrolled for coverage under any other health insurance plan or program.

If You are enrolled for other coverage You must include the name of the other carrier(s).

Payment of Benefits

You may not assign Your Benefits under the Plan to a non-Network Provider without our consent. We may, however, in our discretion, pay a non-Network Provider directly for services rendered to You.

SECTION 14: CLAIMS AND APPEAL NOTICE

Benefit Determinations

Post-service Claims
Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If Your post-service claim is denied, You will receive a written notice from us within 15 business days of receipt of the claim, as long as all needed information was provided with the claim. We will notify You within this 15 business day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend Your claim until all information is received. Once notified of the extension, You then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is determined to be eligible for payment, the claim will be paid immediately. If the claim is determined not eligible for payment and is denied, we will notify You of the denial within 15 days.

If You do not provide the needed information within the 45-day period, Your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Pre-authorization Requests for Benefits

Pre-authorization requests for Benefits are those requests that require authorization prior to receiving medical care. If You have a pre-authorization request for Benefits, and it was submitted properly with all needed information, You will receive notice of the decision from us. We will mail or otherwise transmit such notice to You and to Your Physician not later than 3 calendar days of receipt of the request. If additional information is needed to process the pre-authorization request, we will notify You of the information needed within 3 calendar days after it was received, and may request a one time extension not longer than 15 days and pend Your request until all information is received. Once notified of the extension You then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify You of a non-adverse determination within 2 working days after the information is received. We will notify You of an adverse determination within 3 working days after the information is received If You don't provide the needed information within the 45-day period, Your request for Benefits will be denied. A denial notice of an adverse determination will include:
(1) the principal reasons for the adverse determination;
(2) the clinical basis for the adverse determination;
(3) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and
(4) a description of the procedure for the complaint and appeal process, including notice to You of Your right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations: • You will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written or electronic confirmation to follow within three days. If You filed an urgent request for Benefits improperly, we will notify You of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify You of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information. You will be notified of a benefit determination no later than 48 hours after:
• Our receipt of the requested information; or
• The end of the 48-hour period within which You were to provide the additional information, if the information is not received within that time. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and Your request to extend the treatment is an urgent request for Benefits as defined above, Your request will be decided within 24 hours, provided Your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on Your request for the extended treatment within 24 hours from receipt of Your request. If Your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and You request to extend treatment in a non-urgent circumstance, Your request will be considered a new request and decided according to post-service or pre-authorization timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If You have a question or concern about a benefit determination, You may informally contact our customer service department before requesting a formal appeal. If the customer service representative cannot resolve the issue to Your satisfaction over the phone, You may submit Your question in writing. However, if You are not satisfied with a benefit determination as described above, You may appeal it as described below, without first informally contacting a customer service representative. If You first informally contact our customer service department and later wish to request a formal appeal in writing, You should again contact customer service and request an appeal. If You request a formal appeal, a customer service representative will provide You with the appropriate address. If You are appealing an urgent claim denial, please refer to the *Urgent Appeals that Require Immediate Action* section below and contact our customer service department immediately.

How to Appeal a Claim Decision

If You disagree with a pre-authorization request for Benefits determination or post-service claim determination after following the above steps, You, your Physician, a person acting on your behalf, or other healthcare provider can contact us orally or in writing to formally request an appeal.
The request should include:
• The patient's name and the identification number from the ID card.
• The date(s) of medical service(s).
• The Provider's name.
• The reason You believe the claim should be paid.
• Any documentation or other written information to support Your request for claim payment. Within five working days from the date We receive the appeal, We will send You a letter acknowledging the date of receipt. The letter will include a list of:
(1) the procedures for appeal; and
(2) the documents that the appealing party must submit for review

When We receive an oral appeal of an adverse determination, We will send a one-page appeal form to the appealing party.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If Your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Upon request and free of charge, You have the right to reasonable access to and copies of all documents, records, and other information relevant to Your claim for Benefits.

Appeals Determinations

Pre-authorization Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on Your appeal as follows:

• For appeals of **pre-authorization requests for Benefits** as identified above, the first level appeal will be conducted and You will be notified of the decision within 3 calendar days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and You will be notified of the decision within 3 calendar days from receipt of a request for review of the first level appeal decision.

• For appeals of **post-service claims** as identified above, the first level appeal will be conducted and You will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and You will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision. For procedures associated with urgent requests for Benefits, see *Urgent Appeals That Require Immediate Action* below. If You are not satisfied with the first level appeal decision, You have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. Please note that our decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between You and Your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:
• The appeal does not need to be submitted in writing. You or your physician should call Us as soon as possible.
• We will provide You with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

SECTION 15:

NMHPA - NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

What are the special rights for childbirth under NMHPA?

Policyholder health plans and health insurers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following an uncomplicated vaginal delivery, or less than 96 hours following an uncomplicated cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). **This Act does not change the benefit limits or Deductibles of the Plan.**

WOMEN'S HEALTH AND CANCER RIGHTS ACT - IMPORTANT MASTECTOMY NOTICE

What are the rights for reconstructive surgery after a mastectomy?

Effective October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act. The Act stipulates that any health plan that provides medical benefits for a mastectomy must also provide coverage for breast reconstruction if the Covered Person chooses to receive it. Specifically, any patient who is covered for mastectomy is also covered for reconstruction of the breast on which the mastectomy was performed, reconstruction of the other breast to achieve symmetry, and prostheses and physical complications of all stages of mastectomy including lymphedema. **This Act does not change the benefit limits or Deductibles of the Plan.**